



The Counseling Team International  
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## CONSULTATION REQUEST FORM

Case Number \_\_\_\_\_

Division: \_\_\_\_\_ SAC/ASAC/RAC: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date(s) of Consultation: \_\_\_\_\_ Type of Consultation:  
 Management  Organizational  Crisis Intervention

Purpose for Consultation: (Manager Concerns, Initial Problem Statement)

\_\_\_\_\_  
 \_\_\_\_\_  
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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Estimated Hours Required: \_\_\_\_\_ Estimated Travel Time: \_\_\_\_\_ Estimated Travel Cost: \_\_\_\_\_

Requesting Manager's Name: \_\_\_\_\_  
 Printed Signature

Area Clinician Requested \_\_\_\_\_  
 Printed Signature

Review of Request: \_\_\_\_\_ Date: \_\_\_\_\_  
 Administrative Clinician

Hours Approved: \_\_\_\_\_

DENIED \_\_\_\_\_