The Counseling Team International
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CLINICAL SERVICE RECEIPT

Submit one form for each session

Case Number: _____ **Therapist Name:** _____

Date of Session:_____ **Session #:** _____ **(1-6)** ***Check if this is the Final Session:*** ☐

Session Duration:_____**(Hours)** **EMDR Session:** ☐

I ACKNOWLEDGE THE SERVICES WERE PROVIDED:

_____ _____

Print Name of Employee or Family Member **Signature of client or consenting adult (client under 18)**

Narrative/ Description of Session:

_____

_____

_____

_____

_____

_____

DISCHARGE -DISPOSITION SUMMARY:

If this is the Final Session, please provide a brief summary of any improvements and follow-up recommendations:

_____

_____

_____

_____

_____

Check one: Improved ☐ Not Improved ☐

If recommendation includes additional sessions, please submit Form # 11- Authorization to extend EAP Services