

CONSULTATION SERVICE RECEIPT



Case Number _____ Clinician's Name: _____

Division: _____ Requesting SAC/ASAC/RAC: _____

Office Address: _____ Phone consultation only: Y or N

Date(s) of Consultation: _____

Type of Consultation: ☐ Management ☐ Organizational ☐ Crisis Intervention

Actual Case Problem/Situation Focus:

Actions Taken – Methods Employed:

Results Achieved:

of Managers Involved: _____ # Employees Involved: _____ # of TTM: _____

Actual Consultation Hours Required: _____

Total Travel TIME (combined): _____ Total MILES traveled (roundtrip): _____

Total Travel Costs (Please attach ALL receipts): _____

SAC/ASAC/RAC Name: _____
Printed Signature Date