

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.