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: _____

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**