CLINICAL SERVICE RECEIPT

Submit one form for each session

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

Date of Session:_____ **Session #:** _____ **(1-12)** ***Check if this is the final session:*** ☐

Session Duration:_____**(Hours)**

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 the recommendation is to continue beyond 12 sessions to address the same concern, please submit Form #11: Authorization to extend EAP Services.