NAME: LAST_________________________ FIRST_________________________ MIDDLE INITIAL____

OTHER ATTENDEE NAME____________________________________________________________________

SERVICE TIME: (Indicate time in 15 MINUTE intervals)  

NUMBER PRESENT: ________________________  □ Re-open Case

ATTENDEE TYPE:
1. _____ EMPLOYEE
2. _____ SPOUSE
3. _____ SPOUSE W/EMPLOYEE
4. _____ DEPENDENT
5. _____ FAMILY

CONTACT LOCATION:
1. _____ EAP OFFICE
2. _____ AFFILIATE OFFICE
3. _____ OTHER LOCATION

NATURE OF CONTACT:
1. _____ IN-PERSON
2. _____ TELEPHONE
3. _____ OTHER

**TYPE OF SERVICE:
1. _____ REFERRAL
2. _____ FOLLOW-UP
3. _____ INDIVIDUAL COUNSELING
4. _____ COUPLES COUNSELING
5. _____ FAMILY COUNSELING
6. _____ CRISIS/EMERGENCY INTERVENTION
7. _____ EMPLOYEE HEALTH CONSULT
8. _____ CLINICAL CONSULTATION
9. _____ CX/NS/RS

**SERVICES DIRECTLY ASSOCIATED WITH THIS CLIENT

VISIT #: _____  FOLLOW-UP STATUS: _____

NOTES

_____________________________ , _____________________
COUNSELOR CREDENTIALS

Revised 02.07.2019