PSYCHOLOGICAL CONSULTATION CENTER

Client Contact Sheet

Complete this form *immediately* after seeing client and return to Jean or clinic assistant

DATE_____ CLIENT NAME_____ ID#_____

CLINICIAN_____
SUPERVISOR_____
(complete Transfer Form to transfer to new clinician) ❑ Check if change in supervisor

TYPE OF SERVICE:

❑ Adult Ind. therapy ❑ Pre-intake screening
❑ Child Ind. therapy ❑ Intake assessment (complete Init Dx/Tx Plan)
❑ Family therapy ❑ Assessment: (check all that apply)
❑ Cognitive ❑ Psychodiagnostic
❑ Adult ❑ Child
❑ Missed session* ❑ Cancellation*
❑ Group therapy ❑ Psychiatric Consult (check only if clinician present during eval.)
❑ Couples therapy ❑ Other _____

*check if client is to be charged, use Non-Visit Contact Sheet in client's chart if client is not being charged.

AGREED FEE _____ AMOUNT PAID _____ BALANCE DUE _____

NEXT APPOINTMENT (do not leave blank nor TBA): _____
or ❑ Treatment Terminated (complete termination summary ASAP)

NOTES: _____

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(Use back of sheet for additional notes if needed)

_____ _____
Clinician Signature Supervisor Signature

Length of Session _____

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