MSB CONSULTING

MENTAL HEALTH SESSION NOTES

STUDENT NAME: ______________ DATE OF BIRTH: ______ SAU #: ____

DISTRICT OF LIABILITY: ______________

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Session Date: ______
Start Time: ______
Stop Time: ______
Total Minutes: ______
Circle One: (G) Group (I) Individual

Provider Initial: ____

- [ ] Consultation
- [ ] Family Counseling (student present at some point)
- [ ] Individual Treatment/Therapy/Services
- [ ] Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

Unless so noted, school was in session and students were in attendance on all days recorded above. I have edited this form to correctly reflect services delivered on the above dates.

PRACTITIONER SIGNATURE: ______________ DATE: ______

PRACTITIONER PRINTED NAME: ______________

LICENSE / CERTIFICATION / DOE ENDORSEMENT: ______________