



## Professional Consultation Note

All Sections of this form *except for LCSW Comments/Recommendations* are to be completed by the provider prior to staffing

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Provider: \_\_\_\_\_ Consumer: \_\_\_\_\_

**Service Provided:**

- Habilitation
- Parent Support and Training/Unpaid Caregiver
- Parent Education
- Resource Family Support Service
- Home Based Casework
- Parenting Family Functioning Assessment

**Program:**

- CMHI/CMHW
- DCS Home & Community Based Services
- Choices INC

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**Consultation Focus:**

- New Enrollment
- Case Review
- Crisis Intervention/Planning
- Other: \_\_\_\_\_

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**Developing Strengths & Accomplishments:**

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**Recent Stressors/Youth & Family Challenges/Child & Family Team Challenges:**

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**Consumer Goals & Progress:** (List only those goals included in the approved Plan of Care that are specific to the service being provided.)

**Current Plan of Care on File**

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**LCSW Comments/Recommendations** (To be completed by LCSW during staffing):



<b><u>Supervision &amp; Consultation Note</u></b>	Contact Type: <input type="checkbox"/> Face to Face <input type="checkbox"/> Phone <input type="checkbox"/> Other: _____
Provider Signature: _____ Date: _____	Start Time: _____ End Time: _____
Signature: _____ Date: _____	Duration: _____ Hours _____ Minutes