

NC Division of Mental Health, Developmental
Disabilities and Substance Abuse Services

WESTERN HIGHLANDS

Client:	Record Number:	Date:
Service Authorization #:	Authorization Session of	Duration:
Provider Name: Please Print		Provider ID #:
Case Manager:		
Service Provided: (Check only one. Use a separate form for each service provided.)		
<input type="checkbox"/> Family Counseling	<input type="checkbox"/> Individual Counseling	<input type="checkbox"/> Group Counseling
<input type="checkbox"/> Assessment	<input type="checkbox"/> Evaluation	
Service Note: Recipient; if Different from Client; Purpose of Contact; Description of Intervention/Activity; Effectiveness of Intervention/Activity; Duration of Services (Periodic, Day/Night Services), if not reflected above; Signature and Position		