REQUEST FOR ADDITIONAL THERAPY SESSIONS

IF ADDITIONAL SESSIONS ARE NEEDED, PLEASE COMPLETE THIS FORM AND RETURN IT TO THE COMMISSION PRIOR TO THE INITIAL 30 SESSIONS BEING EXHAUSTED.

THERAPIST’S NAME: ___________________________ LICENSE #: ____________________

VICTIM’S NAME: ____________________________

CLIENT’S NAME: ____________________________

Current Behaviors in Treatment: ___________________________________________________

Reasons for Additional Treatment Request: ___________________________________________

Revised Treatment Goals and Plan: ________________________________________________

Other Pertinent Information: ______________________________________________________

Number of Sessions to Date: ______________________________________________________

Number of Additional Sessions Requested: ___________________________________________

Current Involvement Between the Offender and Victim: ________________________________

Is Treatment Related to the Crime: ________________________________________________

_________________________________________  _______________________________
THERAPIST’S SIGNATURE  DATE