

**GEORGIA DEPARTMENT OF CORRECTIONS – MENTAL HEALTH
SERVICES RECORD OF INDIVIDUAL CLINICAL CASE CONSULTATION**

Institution: _____ Date of Session: _____

Staff Member: _____ Consultant: _____

Start Time of Session: _____ End Time of Session: _____

Offenders/Cases Discussed:

Name	ID#	Name	ID#

Clinical Issues/Concerns: _____

Clinical Consultant Signature

Date