

**Life Management Systems EAP  
Affiliate Treatment Plan**

**(513) 551-1500 PHONE  
800-733-0257 TOLL FREE  
(513) 551-1489 FAX**

All sections must be filled out in full. Please call us if you have any questions.

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**Counselor's Name (print):** \_\_\_\_\_

**Assessment Summary: Client** \_\_\_\_\_ **Sponsor Company** \_\_\_\_\_

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**Treatment Plan:**

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**Additional Sessions Requested =** \_\_\_\_\_

**Diagnostic Impression:** Axis 1 \_\_\_\_\_

Axis 2 \_\_\_\_\_

**Closing Summary: (MUST complete in order to be paid)**

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**REFERRED TO:**

(if applicable) \_\_\_\_\_

**Dates of Service:**

1. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 6. \_\_\_\_\_

**Counselor Signature:** \_\_\_\_\_

3. \_\_\_\_\_ Add'l. \_\_\_\_\_

**Date:** \_\_\_\_\_

4. \_\_\_\_\_ \_\_\_\_\_