|  |  |  |
| --- | --- | --- |
| Therapy Extension Request Form: | | |
| Client Identifying Number: | SS | ACS |
| Clients Surname: |  | |
|  | | |
| Referral Focus / Presenting Issue: |  | |
| Allocated number of sessions: | Current session number: | |
|  | | |
| Request details:  *Please provide supporting information for this request, in particular demonstrating why and how it would be detrimental to the client should therapy conclude within the original number of sessions*  *.* | | |
| Counsellors Name: |  | |
|  | | |
| Date of Request: |  | |

BWS – Additional Sessions Request