

WCSPP TREATMENT SERVICE

TERMINATION SUMMARY

Date: _____ Patients Name: _____

Therapist: _____ Supervisor: _____

Date therapy began: _____ Fee per session: _____

Total number of sessions: _____ Termination/transfer date: _____

Presenting Problem:

Course of Treatment:

Reason for termination and disposition:

Diagnosis: Axis I _____ Axis II _____

Axis III _____ Axis IV _____ Axis V _____

Signature of Therapist: _____

Signature of Supervisor: _____

SUBMIT FORM TO: Nancy Bobker, WCSPP, 260 Stuyvesant Avenue, Rye, NY 10580