

THERAPY CENTER **INTERRUPTION OF TREATMENT**

This form is to be filed once a month during the period of interruption of treatment.

The Therapy Center Faculty Fellow must be informed within twenty-four hours of interruption.

Patient's Name _____

Therapist's Name _____

Date treatment began _____ Frequency of sessions _____

Circumstances of interruption _____

Supervisor's recommendation re: follow up _____

Results of follow up _____

Supervisor's signature _____ Date _____

Therapy Center Faculty Fellow _____ Date _____