Form 5A

THERAPY CENTER **REQUEST TO TRANSFER PATIENT FROM PRIVATE PRACTICE**

NAME OF PATIENT: _____

ADDRESS: _____

_____ZIP CODE:_____

TELEPHONE: HOME (___)_____ WORK (___)_____

NAME OF THERAPIST: _____

SUPERVISOR: _____

HOW LONG HAVE YOU BEEN SEEING THE PATIENT: _____

WHAT ARE THE ISSUES IN TREATMENT:_____

_____

_____

_____

PLEASE DESCRIBE ANY HISTORY OF SUICIDE ATTEMPTS, VIOLENCE, OR ANY PAST OR PRESENT LEGAL PROBLEMS: _____

_____

_____

OTHER: _____

_____

_____

SIGNATURE OF THERAPIST: _____

APPROVED BY: _____