

**Therapy Center
Boston Graduate School of Psychoanalysis**

Termination Report

Patient _____ Fee _____

Address _____ Phone _____

City _____ State _____ Zip _____ Referral Source _____

Therapist _____ Supervisor(s) _____

Date Treatment Began _____ Terminated _____ # of hours _____

Treatment terminated because:

With supervision, I am maintaining contact with the patient: Yes _____ No _____

Patient is referred back to the Center for follow up: Yes _____ No _____

Signature _____ Date _____