



THE INSTITUTE FOR EXPRESSIVE ANALYSIS

TERMINATION REPORT

Please send immediately after termination

Termination Date _____

Name of therapist _____

Patient (Please Print) _____
First Name Last Name

Date Referred _____

Number of Sessions at Termination _____

Referral Fee _____ Sessions per Week _____

Termination Fee _____ (If different)

Patient reasons for termination and therapist understanding of patient's reasons

Should patient continue treatment? _____

If so, can patient be referred back to IEA Consultation Center for reassignment? _____

THERAPIST _____
Print, Sign and Date

SUPERVISOR _____

Please keep a copy of this form for your records and mail a signed copy to IEA CC Director

Gail Elkin-Scott, ATR-BC, LCAT, LP
32 Union Square East, Suite 1218, New York, NY 10003