



## End of Treatment Summary

Protected when completed.

Family name:	Given name(s):	Date of birth: (yyyy-mm-dd)
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Professional:	Report date: (yyyy-mm-dd)
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Type of services offered:     Individual therapy     Couple therapy     Family therapy

If applicable, please provide name(s) of family member(s) who participated in the treatment and their relationship to the client:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This treatment summary addresses the following period:

From: \_\_\_\_\_ (yyyy-mm-dd)    To: \_\_\_\_\_ (yyyy-mm-dd)    Total number of sessions: \_\_\_\_\_

The treatment offered to the client(s) addressed the following condition(s):  
 [Note Diagnostic and Statistical Manual (DSM) diagnoses (if applicable)]

List clinical objective(s) addressed during the course of treatment:

Briefly describe the type(s) of clinical intervention(s) offered to the client(s):

Describe the client's adherence to the treatment process:

- Always adherent     
  Adherent 70% or more of the time     
  Adherent less than 70% of the time

Please elaborate:

Change in condition/symptoms during the course of treatment:

- Marked deterioration - symptoms are more severe  
 No change  
 Improvement in symptoms  
 Marked improvement

Please describe clinical objective(s) that were met or partially met:

If applicable, list clinical objective(s) which could not be addressed during the course of treatment:

Did any factors, intrinsic or extrinsic, to the client(s), prevent optimal treatment efficacy?

Yes  No

If **yes**, please explain:

Reason for termination of the treatment:

Current DSM diagnostic impression and/or professional formulation:

Post-treatment recommendations:

Do you wish to provide any additional information?  
Please elaborate:

Yes  No

Name:

Signature:

Professional title:

Professional corporation:

Registration No.:

Blue Cross No.:

Date: (yyyy-mm-dd)

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