ID: ___________________________

Iowa Department of Human Services

CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC SERVICES

Name of Child_________________________ Birthdate ___________________________

INDEPENDENT TEAM ASSESSMENT

YES	NO	(Please check one choice for each item)
____	____	1. Available community resources for ambulatory care do not meet the treatment needs of this child.
____	____	2. Proper treatment of this child's psychiatric condition requires service on an inpatient basis, under the direction of a physician.
____	____	3. These services can reasonably be expected to improve this child's condition or prevent regression so that the services will no longer be needed.

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Physician Name Date

____

Name and Profession Date

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Name and Profession Date

____

Name and Profession Date

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Name and Profession Date

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