McLAREN FLINT
Flint, Michigan

OUTPATIENT PSYCHIATRIC RECERTIFICATION

1st Re-certification *(On or before the 18th day of service.)*

I certify that the client would require inpatient hospitalization if Partial Hospital services were not available due to the following symptoms:

_____
_____
_____
_____
_____
_____

I estimate the period of therapy will be _____ days per week for a period of _____weeks.

_____
(Attending Physician signature) *(Date)*

2nd Re-certification *(On or before 30th day of treatment).*

I certify that the client would require inpatient hospitalization if Partial Hospital Program services were not available due to the following symptoms.

_____
_____
_____
_____
_____

_____
(Attending Physician signature) *(Date)*

3rd Re-certification. *(On the 60th day of treatment)*

I certify that the client would require inpatient hospitalization if Partial Hospital Program services were not available due to the following symptoms.

_____
_____
_____

_____
(Attending Physician signature) *(Date)*

PT.
MR.#/RM.
DR.