McLaren Flint
PARTIAL HOSPITALIZATION PROGRAM

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)

OUTPATIENT PSYCHIATRIC RECERTIFICATION

17781 (2/15)

660B

PT.

MR.#/RM.

DR.