Please fax completed referral to:
Or via encrypted email completed referral to:
At email address: jtyler@dickinsoncenter.org

CERTIFICATION OF NEED FOR
INPATIENT PSYCHIATRIC HOSPITALIZATION OF A
PERSON UNDER THE AGE OF 22 OR OVER THE AGE OF 65

Date: _____

The undersigned members of the Psychiatric Treatment Team at the

_____ hereby certify that _____, requires
(Name of Referring Agency) (Patient)
psychiatric treatment on an inpatient basis. We have examined said patient and find that:

1. The ambulatory care resources in the community do not meet the needs of the patient; and
2. Inpatient treatment under the direction of a physician is required; and
3. The provision of such services can reasonably be expected to improve the patient's condition or to prevent further regression so the services will no longer be needed.

_____	_____
Psychiatrist/Physician	Name & Title
_____	_____
Psychologist	Name & Title
_____	_____
Social Worker, Registered Nurse or Occupational Therapist	Name & Title

Ref. Authority 42 C.F.R. 441, Subpart D.