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.

Physician Name	Date
Name and Profession	Date
Name and Profession	Date
Name and Profession	Date
Name and Profession	Date