St. Clair County Community Mental Health

Certification Order for Professional Assessment

Individual: _____ Case #: _____

Program(s): _____ Date of Request: _____

~ ASSESSMENTS ORDERED ~

If applicable, the supports coordinator/clinician will write the date of the most recent assessment available in the consumer file after the requested assessment.

- ☐ Nursing _____
- ☐ Clinical _____
- ☐ Nutritional _____
- ☐ Educational _____
- ☐ Speech & Language/Communication _____
- ☐ Psychiatric Assessment_____
- ☐ Psychological Testing _____
- ☐ Vocational Assessment _____
- ☐ Physical Therapy (per OT) _____
- ☐ Other: _____

~ ASSESSMENT REQUEST ~

Reason for Request: _____

☐ Approved ☐ Denied

Type of Assessment: _____

Detailed Reason(s) for Denial:

_____

_____
Requester Signature/Credentials/Date

_____
Assessment Staff Signature/Credentials/Date

_____
*Psychiatrist Signature/Credentials/Date
*(*May be required for some third party payors*)*

~ OPTIONAL ~

Forward completed assessment to: _____

At: _____

Forward completed assessment by: _____

PCP Meeting: ☐ Yes ☐ No; If YES, scheduled as follows:

Date: _____ Time: _____

Place: _____

NOTE DATE OF PCP MEETING:
Assessments should be completed within 30 days before the scheduled meeting.