

Diagnostic Assessment Signature Page
(Determines Medical Necessity for Treatment)

Clinician Signature/Credential

Date

Printed Name: _____

Member/Legally Responsible Representative Signature

Date

Member's Printed Name: _____

Other Participant (if applicable)

Date

Printed Name:

Interdisciplinary team review of assessment findings and recommendations:

Addition to recommended goals as listed above:

Signature/Credential

Date

Farah Sajous, PMHNP-BC, FNP-C, X

Printed Name/ Credentials