Park Center 801 12th Avenue South Nashville, TN 37203 615.242.3576 (F)615.650.8917

Recommendation for Psychiatric Rehabilitation Services

Client Name: _____ Date: _____

The following statement is to be signed by a licensed physician who is treating the client or other licensed healthcare provider practicing within the scope of his/her license who is treating the client or is part of the treatment team.

I, the undersigned, recommend that this client be referred for psychiatric rehabilitation services.

Signed by: _____

Agency: _____