PSSHSP RECOMMENDATION FOR SERVICES

Student Name _____ **DOB** _____

District _____ County NIAGARA

Agency _____

(Agency, Center-based Program or Individual Provider)/Phone

(Check One)

Reason for Rx: ☐ Annual Review Meeting ☐ Change in Service ☐ Transfer Meeting ☐ Re-Eval Meeting ☐ New Referral

TERM OF SERVICE: (Only select one option – Selecting two options will result in an invalid prescription)

SELECT ONE		**Enter Year**			**Enter Year**
☐ **School Year:**	**July 1,**		**To**	**June 30,**	

	FROM DATE	**TO DATE**
☐ **School Session:**		
☐ **Specific Dates:**		

Extended School Year Services (ESY)

Discipline	**Frequency**	**Duration**	**(I/G)**	**ICD Code Services**	**Purpose of Treatment**
Occupational Therapy					
Physical Therapy					
Speech Therapy					

10-Month Services

Discipline	**Frequency**	**Duration**	**(I/G)**	**ICD Code Services**	**Purpose of Treatment**
Occupational Therapy					
Physical Therapy					
Speech Therapy					

Signature _____ **Date Signed** _____

(Required: Original Signature – Stamps Not Permitted)

_____

(Please Print) Ordering Practitioner's Name/Title/Credentials

REQUIRED ORDERING PRACTITIONER INFORMATION (Stamp Accepted)

Address:

Phone:

License # _____

NPI # _____

Medicaid # _____

Phone # _____

Fax # _____