

PSSHSP RECOMMENDATION FOR EVALUATION

Student Name _____ **DOB** _____

District _____ County NIAGARA

Agency _____

(Select all that apply)

x	Discipline	EVALUATION ICD Code(s)	Purpose of Evaluation
<input checked="" type="checkbox"/>	Audiological		
<input type="checkbox"/>	Occupational Therapy		
<input type="checkbox"/>	Physical Therapy		
<input type="checkbox"/>	Speech Therapy		
<input type="checkbox"/>	Psychological		

Signature _____ **Date Signed** _____

(Required: Original Signature – Stamps Not Permitted)

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

REQUIRED ORDERING PRACTITIONER INFORMATION (Stamp Accepted)

<p>Address:</p> <p>Phone:</p>	<p>License # _____</p> <p>NPI # _____</p> <p>Medicaid # _____</p> <p>Phone # _____</p> <p>Fax # _____</p>
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