PSSHSP RECOMMENDATION FOR EVALUATION

Student Name _____ **DOB** _____

District _____ County NIAGARA

Agency _____

(Select all that apply)

x	Discipline	EVALUATION ICD Code(s)	Purpose of Evaluation
☐	Audiological		
☐	Occupational Therapy		
☐	Physical Therapy		
☐	Speech Therapy		
☐	Psychological		

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 # _____