**PSSHSP REFERRAL FOR EVALUATION OR RECOMMENDATION FOR SERVICES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Student Name** |  | **DOB** |  |
|  |  |  |  |
| District |  | County |  |
|  |  |  |  |
| 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 (REQUIRED)**   |  | | --- | | **School Year: 7/1/\_\_\_\_\_\_ to 6/30/ \_\_\_\_\_\_ -OR-  IEP Dates: \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_** |   (Enter School Year) (Select One) ( Enter IEP Service Dates for Calendar Year IEPs)  ***\*\*Frequency/Duration adopted “As per IEP” requires a New Order each time the IEP is changed for ALL Services\*\****   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Discipline** | **Frequency** | **Duration** | **(I/G)** | **ICD Code**  **Services** | **Purpose of Treatment / Services** | **ICD Code**  **Evaluations** | | **Audiological** |  |  |  |  |  |  | | **Occupational Therapy** |  |  |  |  |  |  | | **Physical Therapy** |  |  |  |  |  |  | | **Speech** |  |  |  |  |  |  | | **Psychological/**  **Psychological Counseling** |  |  |  |  |  |  | | **Skilled Nursing**  (Requires a Physician’s Order) |  |  |  |  |  |  | |

*(Signature of NYS licensed and registered physician, a physician or a licensed nurse practitioner acting within the scope of practice (for psychological counseling services this also includes an appropriate school official and for speech therapy services, a speech-language pathologist who has seen the child.)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature** |  | **Date Signed** |  |
|  | **(Required: Original Signature – Stamps Not Permitted)** |  |  |
|  | | | |
| **(Please Print) Ordering Practitioner’s Name/Title/Credentials** | | | |

**REQUIRED ORDERING PRACTITIONER INFORMATION** (Stamp Accepted)

|  |  |  |  |
| --- | --- | --- | --- |
| **Address:** |  | **License #** |  |
|  |  |  |  |
|  |  | **NPI #** |  |
|  |  |  |  |
|  |  | **Medicaid #** |  |
|  |  |  |  |
|  |  | **Phone #** |  |
|  |  |  |  |
| **Phone:** |  | **Fax #** |  |