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:

Phone:

License # _____

NPI # _____

Medicaid # _____

Phone # _____

Fax # _____