**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 Dates) **(Select One)** (Enter IEP 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** | | **Occupational Therapy** |  |  |  | Check Code  Below |  |  | | **Physical Therapy** |  |  |  | Check Code  Below |  |  | |

**Frequently Used OT/PT ICD Codes:**

|  |  |  |
| --- | --- | --- |
| (Check) | **ICD Code** | **Description (Frequency, Duration & Class Ratio as per the IEP)** |
|  | **F82** | Coordination Disorder |
|  | **F84.0** | Autism |
|  | **R62.50** | Unspecified lack of expected normal physiological development in childhood |
|  | **R26.89** | Abnormality of Gait: Ataxic, paralytic, spastic, staggering |
|  | **R27.8** | Lack of Coordination: Ataxia, not otherwise specified; muscular incoordination |
|  | **Other:** |  |

*(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)** |  |  |
|  | | | |
| **Ordering Practitioner’s Name/Title/Credentials (Please Print)** | | | |

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

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