**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 #** |   |