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:

Phone:

License # _____

NPI # _____

Medicaid # _____

Phone # _____

Fax # _____