PSSHSP 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**

Service	From Date	To Date	Frequency	Duration	Individual(I) / Group(G)	Weekly / Monthly	ICD Code(s)

Write the ICD Code in the ICD Code Column – Please do not circle code.

ICD Code	Description	ICD Code	Description
F82	Coordination Disorder	**R27.8**	Lack of Coordination: Ataxia, not otherwise specified; muscular incoordination
R62.0	Delayed Milestones in Childhood	**F84.0**	Autism
R62.50	Unspecified lack of expected normal physiological development in childhood	**Q90.9**	Down Syndrome, Unspecified
R26.89	Abnormality of Gait: Ataxic, paralytic, spastic, staggering		

(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)

REQUIRED ORDERING PRACTITIONER INFORMATION (Stamp Accepted)

Address:

Phone:

License # _____

NPI # _____

Medicaid # _____

Phone # _____

Fax # _____