SPACE FOR SCHOOL/AGENCY INFORMATION

(You can list your company address and phone number here to be sure that it is included on the order.)

PSSHSP REFERRAL FOR EVALUATION OR RECOMMENDATION FOR SERVICES

| recommendatio | • • | elow will be provided | • | ication, a referral for evaluation and/or a dividualized Education Program (IEP) designed |
|--|-------------------------------|--|--------------------------------------|---|
| Student Name | John Smith | | DOB | 1/2/15 |
| District | Optional | | County | Optional |
| Agency | Optional | | | |
| (Check One) Reason for Rx: | ☐ Annual Review Meeting | | gram or Individual Provider) | |
| (Required) | | | | |
| Term of Service | ce: School Year Jul | y 1, <u>2019</u> to J | une 30, 2020 | (Frequency, Duration & Class Ratio as per the IEP) |
| Evaluation/Service | | (Required) ICD CODE for EVALUATION(S) | (Required) ICD CODE for SERVICE(S) * | Medical Diagnosis/Purpose of Treatment |
| Audiological | | | | |
| Occupational The | erapy | | | |
| Physical Therapy | | | | |
| Speech | | | F80.2 | Mixed receptive-expressive language disorder |
| Psychological/Psy | ychological Counseling | | | |
| Skilled Nursing (Requires a Physician's Order) | | | | |
| | ledicaid requires that a w | vritten referral be in order/referral for services | must be completed for each | ation of evaluations/services. |
| Signature Handwritten Signature or Electronic Si Original Signature Required – Stamps Not Perr | | | | gned Date is Required (Required) |
| | Original Signature Required – | stamps Not Permitted) (i | REQUIRED) | (nequireu) |
| Print Name | PRINT NAME HERE (Sta | amp Accepted) | | Title M.D. |
| Address & Phone (Required) - (Stamp Accepted) | | | (Required) License # | 123456 (REQUIRED) |
| REQUIRED: COMPLETE ADDRESS & PHONE # | | | (Required) NPI # | 1234567890 (REQUIRED) |
| ABC Agency 123 Main St. | | | Medicaid # | |
| New York City, NY 12345 (000) 123-4567 | | | Fax # | |