**PSSHSP REFERRAL FOR EVALUATION OR RECOMMENDATION FOR SERVICES**

In accordance with the request by the Committee on Preschool Special Education, a referral for evaluation and/or a recommendation for services as noted below will be provided as specified in the Individualized Education Program (IEP) designed by the Committee. (Check one or both as required**)**  **Evaluation  Services**

|  |  |  |  |
| --- | --- | --- | --- |
| **Student Name** |  | **DOB** |  |
|  |  |  |  |
| District |  | County |  |
|  |  |  |  |
| Agency |  | | |

(Agency, Center-based Program or Individual Provider)/Phone

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **(Required)**  **Term of Service: School Year July 1,** | | | | **20** | **to June 30,** | | **20** |  | |
| **(Required)** Check Appropriate Service(s) / Evaluation(s) | | | | | | | | | |
| **OT** – Service | | | **PT** – Service | | | **OT** - Evaluation | | | **PT** – Evaluation |
| **(Required) ICD CODE / MEDICAL DIAGNOSIS-PURPOSE OF TREATMENT** | | | | | | | | | |
| (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 |  |  | | | | | | | |
| (Please Specify) |  |  | | | | | | | |
| ***The most specific ICD code is required for each evaluation/service***.  ***Medicaid requires that a written referral be in place prior to the initiation of evaluations/services.*** | | | | | | | | | |

***\**** *An order/referral for services must be completed for each IEP period.*

*A new order/referral must be completed whenever reviews conducted during an IEP period results in a change in service (i.e., frequency/duration/ratio).*

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature** |  | **Date Signed** |  |
|  | **(Original Signature Required – Stamps Not Permitted)** |  | **(Required)** |
|  |  |  |  |
| Print Name |  | Title |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Address & Phone (Required) - (Stamp Accepted)** | **(Required)** | **License #** |  |
|  |  |  |  |
|  | **(Required)** | **NPI #** |  |
|  |  |  |  |
|  |  | Medicaid # |  |
|  |  |  |  |
|  |  | Fax # |  |

*(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.)*