PSSHSP REFERRAL FOR OT/PT SERVICES

Student Name JANE DOE **DOB** 1/21/21

District OPTIONAL County OPTIONAL

Agency OPTIONAL

(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) (**ONLY SELECT ONE OPTION**)

☒ **School Year: 7/1/_25____ to 6/30/_26_____** -OR- ☐ **Specific Dates: ____ to ____**

☐ **School Session _____ to _____**

(Calendar Year Annual Review Dates)

** ESY services MUST be in the Summer Session grid and Winter session services MUST be in the 10-month Session grid. **

Summer Session					10-Month Session			
SERVICE	**FREQUENCY**	**DURATION**	**(I/G)**		**SERVICE**	**FREQUENCY**	**DURATION**	**(I/G)**
Occupational Therapy			I		Occupational Therapy	1	30	I
Occupational Therapy			G		Occupational Therapy			G
OT ICD Code(s)	PRACTITIONER MUST ENTER OT CODE(S) HERE				**OT ICD Code(s)**	PRACTITIONER MUST ENTER OT CODE(S) HERE		
Physical Therapy			I		Physical Therapy			I
Physical Therapy			G		Physical Therapy			G
PT ICD Code(s)	PRACTITIONER MUST ENTER PT CODE(S) HERE				**PT ICD Code(s)**	PRACTITIONER MUST ENTER PT CODE(S) HERE		

FREQUENTLY-USED ICD CODES – Enter the appropriate ICD code(s) next to the specific service above.

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 Handwritten or Electronic Signature Only. Electronic Signature must meet Federal, State and Medicaid Guidelines

(Required: Original Signature – Stamps Not Permitted)

Date Signed MM/DD/YY

Ordering Practitioner's Name/Title/Credentials (Please Print) Print the Ordering Practitioner's Name, Title, Credentials

REQUIRED ORDERING PRACTITIONER INFORMATION (Stamp Accepted)

Address:
ABC Agency
123 Main St.
Albany, NY 12345

Phone: (123) – 456-7890

License # 123456 (Required)

NPI # 1234567890 (Required)

Medicaid #

Phone # (123) – 456-7890

Fax #