

**PSSHSP REFERRAL FOR OT/PT SERVICES**

Student Name SAMPLE DOB 1/1/21 (optional – must be correct)

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/\_26 to 6/30/\_27 -OR-  Specific Dates: \_\_\_\_\_ to \_\_\_\_\_  
 School Session \_\_\_\_\_ to \_\_\_\_\_ (Calendar Year Annual Review Dates)

Summer Session				10-Month Session			
SERVICE	FREQUENCY	DURATION	(I/G)	SERVICE	FREQUENCY	DURATION	(I/G)
Occupational Therapy	1	30	I	Occupational Therapy	1	30	I
Occupational Therapy	2	30	G	Occupational Therapy	2	30	G
<b>OT ICD Code(s)</b>	F84.0			<b>OT ICD Code(s)</b>	F84.0		
Physical Therapy	1	30	I	Physical Therapy	1	30	I
Physical Therapy	2	30	G	Physical Therapy	2	30	G
<b>PT ICD Code(s)</b>	F84.0			<b>PT ICD Code(s)</b>	F84.0		

**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 PRACTITIONER Date Signed PRACTITONER  
(Required: Original Signature – Stamps Not Permitted)

Ordering Practitioner’s Name/Title/Credentials (Please Print)

**REQUIRED ORDERING PRACTITIONER INFORMATION (Stamp Accepted)**

Address:  
  
123 Main Street  
Anytown, NY  
  
 Phone: (000)-000-0000

License # PRACTITIONER

NPI # PRACTITIONER

Medicaid # optional

Phone # (000)-000-0000

Fax # optional