

PSSHSP RECOMMENDATION FOR 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 (Only select one option – Selecting two options will result in an invalid prescription)

SELECT ONE Enter Year Enter Year

<input type="checkbox"/> School Year:	July 1,	2026	To	June 30,	2027
<input type="checkbox"/> School Session:	FROM DATE		TO DATE		
<input type="checkbox"/> Specific Dates:					

Extended School Year Services (ESY)

Discipline	Frequency	Duration	(I/G)	ICD Code Services	Purpose of Treatment
Occupational Therapy	2	30	I	F84.0	
Physical Therapy	3 1	30 30	I G	F84.0	
Speech Therapy					
Psychological Counseling					

10-Month Services

Discipline	Frequency	Duration	(I/G)	ICD Code Services	Purpose of Treatment
Occupational Therapy	2	30	I	F84.0	
Physical Therapy	4	30	I	F84.0	
Speech Therapy					
Psychological Counseling					

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

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

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