

PSSHSP RECOMMENDATION FOR SERVICES

Student Name **SAMPLE**

DOB **1/1/22 – 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

Service	Term of Service FROM	Term of Service TO	Frequency	Duration	I/G	Delivery	ICD Code(s)
OT	7/1/26	8/31/26	2	30	I	weekly	F84.0
PT	7/1/26	8/31/26	1	30	I	weekly	F84.0
OT	9/1/26	6/30/27	2	30	I	weekly	F84.0
OT	9/1/26	6/30/27	1	30	G	weekly	F84.0
PT	9/1/26	6/30/27	1	30	I	weekly	F84.0

Write the ICD Code in the ICD Code Column – Please do not circle code.

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 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.))

Signature **PRACTITONER**

Date Signed **PRACTITONER**

(Required: Original Signature – Stamps Not Permitted)

PRACTITONER

(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 # **PRACTITONER**

NPI # **PRACTITONER**

Medicaid # **Optional**

Phone # **(000)-000-0000**

Fax # **optional**