

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
PSY	7/1/26	8/31/26	1	60	G	Weekly	F84.0
OT	9/1/26	6/30/27	3	30	I	Weekly	F84.0
PT	9/1/26	6/30/27	2	30	I	Weekly	F84.0
PSY	9/1/26	6/30/27	2	60	G	Weekly	F84.0

(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 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