**PSSHSP REFERRAL FOR EVALUATION OR RECOMMENDATION FOR SERVICES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Student Name** |  | **DOB** |  |
|  |  |  |  |
| District |  | County |  |
|  |  |  |  |
| Agency |  |

 (Agency, Center-based Program or Individual Provider)/Phone

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  **(Check One)** **Reason for Rx:** [ ]  **Annual Review Meeting** [ ]  **Change in Service** [ ]  **Transfer Meeting** [ ]  **Re-Eval Meeting** [ ]  **New Referral** **TERM OF SERVICE (REQUIRED)**

|  |
| --- |
| [ ]  **School Year: 7/1/\_\_\_\_\_ to 6/30/ \_\_\_\_\_\_ -OR-** [ ]  **IEP Dates: \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_**[ ]  **School Session: \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_**  |

 (Enter School Year or School Session) (Select One) (Enter IEP Service Dates for **Calendar Year IEPs**) ***\*\*Frequency/Duration adopted “As per IEP” requires a New Order each time the IEP is changed for ALL Services\*\****

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Discipline** | **Frequency**  |  **Duration**  |  **(I/G)** |  **ICD Code** **SERVICES** | **Purpose of Treatment / Services** |  **ICD Code****EVALUATIONS** |
| **Audiological** |  |  |  |  |  |  |
| **Occupational Therapy** |  |  |  |  |  |  |
| **Physical Therapy** |  |  |  |  |  |  |
| **Speech** |  |  |  |  |  |  |
| **Psychological/****Psychological Counseling** |  |  |  |  |  |  |
| **Skilled Nursing**(Requires a Physician’s Order) |  |  |  |  |  |  |

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*(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** |  | **Date Signed** |  |
|  |  **(Required: Original Signature – Stamps Not Permitted)** |  |  |
|  |
|  **(Please Print) Ordering Practitioner’s Name/Title/Credentials**  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Address:** |  | **License #** |   |
|   |  |  |  |
|   |  | **NPI #** |   |
|   |  |  |  |
|   |  | **Medicaid #** |   |
|   |  |  |  |
|   |  | **Phone #** |   |
|   |  |  |  |
| **Phone:** |  | **Fax #** |   |