PRESCRIPTION ~ REFERRAL FOR PRESCHOOL EVALUATIONS ~ SERVICES

Student Name: _____ **DOB:** _____

District: _____

The child named above is recommended for the following:
(You must provide the **most specific ICD 10 Codes** (5 digit if possible) for each Evaluation/Service checked.

EVALUATION(S)		**SERVICE(S)**	
		Frequency & Duration as per the IEP, for the School Year: 7/1/_____ (yyyy) to 6/30/_____ (yyyy)	
__ Audiological	ICD 10 Code _____	__ Audiological	ICD 10 Code _____
__ Occupational Therapy	ICD 10 Code _____	__ Occupational Therapy	ICD 10 Code _____
__ Physical Therapy	ICD 10 Code _____	__ Physical Therapy	ICD 10 Code _____
__ Speech*	ICD 10 Code _____	__ Speech*	ICD 10 Code _____
__ Skilled Nursing**	ICD 10 Code _____	__ Skilled Nursing**	ICD 10 Code _____
__ Psychological***	ICD 10 Code _____	__ Psychological Counseling***	ICD 10 Code _____
*** or Reason/Need: _____		*** or Reason/Need: _____	

* Referrals for Speech Evaluation or Services may be signed by a Speech Language Pathologist who has seen the child

** Referrals for Skilled Nursing Services require specific physician's order with specific instructions

*** Referrals for Psychological Evaluation or Psychological Counseling Services may be signed by an appropriate school official such as school administrator or the chairperson of the CPSE or a licensed practitioner acting within his/her scope of practice; Psychological Evaluation and/or Psychological Counseling can have ICD9 Code OR Reason/Need: all others need ICD9

_____ **Date:** _____
Original Signature of Physician, Physician Assistant, Nurse Practitioner or other professional explained above.

Print Name: _____ **Title:** _____
Address/Printed or Stamp:
_____ **NPI #:** _____
_____ **License #:** _____
_____
Phone: _____ **Fax:** _____

~Changes in frequency, duration or type of service need new prescription/referral~