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# Physician Prescription for Evaluations

Based on a review of the child’s records, I am referring this child for the following evaluation(s):

Student’s Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Agency, Center Based School or Individual Provider)

|  |
| --- |
| Type Of Evaluation  (Please check any that apply) |
| Audiological  Neurological  Orthopedic  Psychological  Psychiatric  Occupational Therapy  Physical Therapy  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Diagnosis (ICD 10 code) REQUIRED for Services provided on or after 10/01/2015.**

**Diagnosis (ICD 9code) REQUIRED for Services provided *prior to* 10/01/2015.**

Note: Please provide an ICD9 and an ICD 10 code for each evaluation selected

|  |  |
| --- | --- |
| \*REQUIRED  **Reason for Evaluation:**  **(Presenting Problem &**  **ICD-9 & ICD-10 code)** |  |

Physician/Physician’s Assistant/Nurse Practitioner Information

(Please print or use stamp):

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
|  |  |
| Phone Number: |  |
| License # (REQUIRED) |  |
| NPI # (REQUIRED) |  |
| Medicaid Provider # (REQUIRED) |  |

\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician/Physician’s Assistant/Nurse Practitioner Date

**Must be original signature: STAMPED SIGNATURE WILL NOT BE ACCEPTED**

A FACSIMILE OR PHOTOCOPY OF THIS RX IS ACCEPTABLE.