***Psychological Counseling Referral for Evaluation / Services***

A referral for psychological **evaluation** and/or psychological counseling **services** is recommended in accordance with the request by the Committee on Pre-School Special Education.

Services, when provided, will be in accordance with the Individualized Education Program designed by the Committee.

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Agency, Center based Program or Individual Provider)

District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Year: ***July 1, 2015 thru June 30, 2016***

□ EVALUATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason for Evaluation (Presenting Problem)

□ SERVICES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Diagnosis (ICD-9 code & ICD-10) REQUIRED***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please Print Name) Signature**

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

Date Signed Title of Authorizing Entity

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Must be hand written signature; STAMPED SIGNATURE WILL NOT BE ACCEPTED**

**Note**: Medicaid requires that psychological evaluations or psychological counseling services be recommended by an appropriate school official, such as a school administrator or chairperson of the CSE/CPSE or other licensed practitioner acting within his or her scope of practice or Physician, Physician’s Assistant or Nurse Practitioner on or before the evaluation or start of services.

A FACSIMILE OR PHOTOCOPY OF THIS FORM IS ACCEPTABLE.