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***Speech Referral for Evaluation or Recommendation for Services***

***(You must use a separate form for each*.)**

A Speech and Language referral for an **evaluation** or a recommendation for **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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.**

□ EVALUATION

**Reason for Evaluation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use the ICD9 code prior to 10/01/2015, the ICD-10 code for evaluations 10/01/2015 or later and describe the Presenting Problem if no diagnosis exists at time of evaluation.

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

REQUIRED - Use as many ICD9 and ICD 10 codes as appropriate

* Use official ICD-10 code for services given 10/01/2015 or later
* Use official ICD-9 code for services given prior to 10/01/2015

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please Print Name)** **NYS Licensed Speech Pathologist**

Medicaid provider **Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date**

**License Number:** \_\_\_\_\_\_\_\_\_\_\_\_ **NPI** **Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Signed:** \_\_\_\_\_\_\_\_\_\_\_

**Note**: Medicaid requires that speech evaluations and services be recommended by a Licensed Speech Pathologist, Physician, Physician’s Assistant, or Nurse Practitioner **prior to or on** the date of the evaluation or the start of services.

**\*Must be original signature – Stamped Signature will not be accepted.**

A FACSIMILE OR PHOTOCOPY OF THIS RECOMMENDATION IS ACCEPTABLE.