**SUFFOLK COUNTY DEPARTMENT OF HEALTH**

**OFFICE OF CHILDREN WITH SPECIAL NEEDS**

**Preschool Special Education Program**

# Prescription/Recommendation 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: \_\_\_\_\_\_\_\_\_\_\_\_ CIN: \_\_\_\_\_\_\_\_\_\_\_\_\_

School/Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Agency, Center Based School or Individual Provider)

|  |
| --- |
| Type Of Evaluation  (Please check any that apply) |
| Audiological  Medical  Medical Specialist  Psychological  Occupational Therapy  Physical Therapy  Speech Therapy  Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **\*REQUIRED**  **ICD-10 CODE:**  **Reason for Evaluation:** |  |

Physician/Physician’s Assistant/Nurse Practitioner/SLP Information

(Please print or use stamp):

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

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

Signature of Physician/P.A./Nurse Practitioner/SLP Date Signed

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

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

A FACSIMILE OR PHOTOCOPY OF THIS FORM IS ACCEPTABLE