SUFFOLK COUNTY
DEPARTMENT OF HEALTH SERVICES
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

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: _____ CIN: _____

Date of Birth: _____

Provider: _____
(Agency, Center based Program or Individual Provider)

District: _____

School Year: ***July 1, 2022 thru June 30, 2023***

☐ EVALUATION: _____
ICD-10 code (REQUIRED), Reason for Evaluation (Presenting Problem)

☐ SERVICES: _____
Diagnosis (ICD-10 CODE) REQUIRED

_____ X_____
(Please Print Name) **Signature**

_____ _____
Date Signed Title of Authorizing Entity

License #: _____ NPI #: _____ Medicaid #: _____

Address and Phone #: _____

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.