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 (**REQUIRED**):
(Please print or use stamp)

Name **(REQUIRED)**:	
Address **(REQUIRED)**:	
Phone # **(REQUIRED)**:	
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