

**Westchester County
Preschool Special Education Program
PRESCRIPTION ~ REFERRAL FOR EVALUATIONS ~ SERVICES**

Student Name: _____ **DOB:** _____

District: _____

The child named above is recommended for the following:

<u>EVALUATION(S)</u>	<u>SERVICE(S)</u>
___ Audiological ICD 10 Code _____ ___ Occupational Therapy ICD 10 Code _____ ___ Physical Therapy ICD 10 Code _____ ___ Speech* ICD 10 Code _____ ___ Skilled Nursing** ICD 10 Code _____ ___ Psychological*** ICD 10 Code _____ *** or Reason/Need: _____	Frequency & Duration as per the IEP, for the School Year: 2022-2023 ___ Audiological ICD 10 Code _____ ___ Occupational Therapy ICD 10 Code _____ ___ Physical Therapy ICD 10 Code _____ ___ Speech* ICD 10 Code _____ ___ Skilled Nursing** ICD 10 Code _____ ___ Psychological ICD 10 Code _____ Counseling*** *** or Reason/Need: _____

* Referrals for Speech Evaluation or Services may be signed by a Speech Language Pathologist who has seen the child
 ** Referrals for Skilled Nursing Services require specific physician's order with specific instructions
 *** Referrals for Psychological Evaluation or Psychological Counseling Services may be signed by an appropriate school official such as school administrator or the chairperson of the CPSE or a licensed practitioner acting within his/her scope of practice; Psychological Evaluation and/or Psychological Counseling can have ICD9 Code OR Reason/Need: all others need ICD9

Date: _____

Original Signature of Physician, Physician Assistant, Nurse Practitioner or other professional explained above.

Print Name: _____
Address/Printed or Stamp:

Title: _____
NPI #:
License #:
Medicaid Provider #
Fax: _____

Phone: _____

~Changes in frequency, duration or type of service need new prescription/referral~