**PSSHSP REFERRAL FOR EVALUATION OR RECOMMENDATION FOR SERVICES**

In accordance with the request by the Committee on Preschool Special Education, a referral for evaluation and/or a recommendation for services as noted below will be provided as specified in the Individualized Education Program (IEP) designed by the Committee. (Check one or both as required.) ☐ **Evaluation** ☐ **Services**

**Student Name** _____ **DOB** _____

District _____ County _____

Agency _____
(Name of Agency, Center-based Program or Individual Provider / Phone)

(Check One)
**Reason for Rx:** ☐ **Annual Review Meeting** ☐ **Change in Service** ☐ **Transfer Meeting** ☐ **Re-Eval Meeting** ☐ **New Referral**

TERM OF SERVICE:
(REQUIRED) **School Year: July 1,** 20___ **to June 30,** 20___ **(Frequency, Duration & Class Ratio as per the IEP)**

**(Please type in the last two digits of the school year. Format YYYY.)**

| **Evaluation/Service** | **(REQUIRED) ICD CODE for EVALUATION(S)** | **(REQUIRED) ICD CODE for SERVICE(S) *** | **Medical Diagnosis/Purpose of Treatment** |
|---|---|---|---|
| Audiological | | | |
| Occupational Therapy | | | |
| Physical Therapy | | | |
| Speech | | | |
| Psychological/Psychological Counseling | | | |
| Skilled Nursing **(Requires a Physician's Order)** | | | |

***The most specific ICD code is required for each evaluation/service*.**
***Medicaid requires that a written referral be in place prior to the initiation of evaluations/services.***

** An order/referral for services must be completed for each IEP period.*
*A new order/referral must be completed whenever reviews conducted during an IEP period results in a change in service (i.e., frequency/duration/class size).*

**Signature** _____ **Date Signed** _____
**(Original Signature Required – Stamps Not Permitted)** **(Required)**

Print Name _____ Title _____

**(REQUIRED) - (Stamp Accepted)**
**Address**

**Phone**

**(REQUIRED) License #** _____

**(REQUIRED) NPI #** _____

Medicaid # _____

Fax # _____

*(Signature of NYS licensed and registered physician, a physician or a licensed nurse practitioner acting within the scope of practice (for psychological counseling services this also includes an appropriate school official and for speech therapy services, a speech-language pathologist who has seen the child.)*