THIS FORM TO BE USED AS OF 10/1/2015 IF NEW ICD-10 REQUIREMENT IS PUT INTO EFFECT

Putnam County Department of Health

110 Old Route 6, Building 3, Carmel, NY 10512, 845-808-1640 FAX: 845-808-4092

PRESCRIPTION ~ REFERRAL FOR PRESCHOOL EVALUATIONS ~ SERVICES

Student Name: _____ **DOB:** _____

District: _____

The child named above is recommended for the following:

(You must provide the **most specific ICD-10 Code** (5 digit if possible) for each Evaluation/Service checked)

EVALUATION(S)		**SERVICE(S)**	
		Frequency & Duration as per the IEP, for the School Year: 7/1/_____ (yyyy) to 6/30/_____ (yyyy)	
__ Audiological	ICD10Code _ _ _ _ _	__ Audiological	ICD10 Code _ _ _ _ _
__ Occupational Therapy	ICD10 Code _ _ _ _ _	__ Occupational Therapy	ICD10 Code _ _ _ _ _
__ Physical Therapy	ICD10 Code _ _ _ _ _	__ Physical Therapy	ICD10 Code _ _ _ _ _
__ Speech*	ICD10 Code _ _ _ _ _	__ Speech*	ICD10 Code _ _ _ _ _
__ Skilled Nursing**	ICD10 Code _ _ _ _ _	__ Skilled Nursing**	ICD10 Code _ _ _ _ _
__ Psychological***	ICD10 Code _ _ _ _ _	__ Psychological Counseling***	ICD10 Code _ _ _ _ _
*** or Reason/Need: _____		*** 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: _____ **Title:** _____

Address/Printed or Stamp:

_____ **NPI #:** _____

_____ **License #:** _____

_____ **Medicaid #:** _____

Phone: _____ **Fax:** _____

~A Copy of this form or its equivalent must be sent to the County~
Facsimile or photocopy of this is acceptable

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

Universal Form Revised for use as of 10/1/2015 if ICD10 Codes are required