**ARDSLEY UNION FREE SCHOOL DISTRICT**
500 FARM ROAD, ARDSLEY, NEW YORK 10502
PHONE (914) 295-5500 | FAX (914) 231-0878
www.ardsleyschools.org

## PRESCRIPTION/ REFERRAL FOR PRESCHOOL EVALUATIONS/ SERVICES

**Student Name:** ______________________________ **DOB:** ______________

**School District:** ______________________________

The child named above is recommended for the following:
(You must provide the **most specific** **ICD10 Code** for each Evaluation/Service checked)

| **EVALUATION(S)** | | **SERVICE(S)**<br>Frequency & Duration as per the IEP, for the School Year: __________ to __________ | |
|---|---|---|---|
| __ Audiological | ICD10 Code ______ | __ 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 ______ |
| *** Reason/Need: Developmental Delay | | *** 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 a 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 below)

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

**Universal Form 12/2012 (revised July 2015)**