PROFESSIONALS' ORDER/REFERRAL FOR HEALTH RELATED SUPPORT SERVICES INDICATED ON A STUDENT'S IEP

Child's Name: _____

DOB: _____

Diagnosis and/or reason/need for ordered services: ST ____ OT____ PT____

ICD-9: _____ ICD- 9: _____ ICD- 9: _____ ICD- 9: _____

ICD-10: _____ ICD-10: _____ ICD-10: _____ ICD-10: _____

☐ All necessary evaluations/procedures for the therapies identified below should be provided to this student. I have examined the child and in my professional opinion, the following services are deemed medically necessary.

Please check all that apply:

IEP Start Date: _____ End Date: _____

☐ Speech and Language Therapy Frequency/ duration _____ X week X ____ min ____ Ind ____Grp

☐ Occupational Therapy Frequency/ duration _____ X week X ____ min ____ Ind ____Grp

☐ Physical Therapy Frequency/ duration _____ X week X ____ min ____ Ind ____Grp

☐ Psychological Counseling Frequency/ duration _____ X week X ____ min ____ Ind ____Grp

☐Skilled Nursing Services: _____

_____

Ordering Professional's Signature and Date: _____ _____
Date (handwritten)

Professional's License Number: _____

Professional's National Provider Identification Number (NPI): _____

Professional's Contact Information:

(may use stamp or pre-print address)

Please insure Order/Referral form is accurate and fully completed.