



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

Attn: Judy Goldstein

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)	
		Frequency & Duration as per the IEP, for the School Year: _____ to _____	
<input type="checkbox"/> Audiological	ICD10 Code _____	<input type="checkbox"/> Audiological	ICD10 Code _____
<input type="checkbox"/> Occupational Therapy	ICD10 Code _____	<input type="checkbox"/> Occupational Therapy	ICD10 Code _____
<input type="checkbox"/> Physical Therapy	ICD10 Code _____	<input type="checkbox"/> Physical Therapy	ICD10 Code _____
<input type="checkbox"/> Speech*	ICD10 Code _____	<input type="checkbox"/> Speech*	ICD10 Code _____
<input type="checkbox"/> Skilled Nursing**	ICD10 Code _____	<input type="checkbox"/> Skilled Nursing**	ICD10 Code _____
<input type="checkbox"/> Psychological***	ICD10 Code _____	<input type="checkbox"/> Psychological Counseling***	ICD10 Code _____
*** Reason/Need: <u>Developmental Delay</u>		*** 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): _____

 Phone: _____ NPI # _____
 License # _____
 Medicaid # _____
 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~