

NASSAU COUNTY DEPARTMENT OF HEALTH OFFICE OF CHILDREN WITH SPECIAL NEEDS PRESCHOOL SPECIAL EDUCATION PROGRAM
(60 CHARLES LINDBERGH BLVD. SUITE 100, UNIONDALE, NEWYORK 11553-3683)
PRESCRIPTION FOR PRESCHOOL BASED RELATED SERVICES

Student Name

DOB

District

Agency

Just Kids Early Childhood Learning Center

(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:

7/1/25 to 6/30/26

Frequency/Duration adopted “As per IEP” requires a New Order each time the IEP is changed for ALL Services*

Discipline	Frequency	Duration	(I/G)	ICD Code Services	Purpose of Treatment/Services
OT- ESY					
OT- 10-Month					
PT- ESY					
PT- 10-Month					

Frequently Used OT/PT ICD Codes – Check all that apply or add ICD Codes using the Other Category.

(Check)	ICD Code	Description (Frequency, Duration & Class Ratio as per the IEP)
	F82	Coordination Disorder
	F84.0	Autism
	R62.50	Unspecified lack of expected normal physiological development in childhood
	R26.89	Abnormality of Gait: Ataxic, paralytic, spastic, staggering
	R27.8	Lack of Coordination: Ataxia, not otherwise specified; muscular incoordination
	Other:	

(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.)

Signature

Date Signed

(Required: Original Signature – Stamps Not Permitted)

Ordering Practitioner’s Name/Title/Credentials (Please Print)

REQUIRED ORDERING PRACTITIONER INFORMATION (Stamp Accepted)

Address:

Phone:

License #

NPI #

Medicaid #

(Required)

Phone #

Fax #