SUFFOLK COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

PRESCRIPTION/RECOMMENDATION FOR PRESCHOOL SERVICES

Student's Name: _____ DOB: _____ CIN: _____

School/Provider:_____ District: _____
(Agency, Center Based School or Individual Provider)

The child named above is recommended for the following service(s). Services when provided will be in accordance with the Individualized Education Program designed by the Committee.

Period of Service: School Year **7/1/2023 - 6/30/2024**

Diagnosis (ICD-10 code) REQUIRED

You must provide the MOST SPECIFIC ICD-10 CODE(S) for each service checked.

Service/Therapy **Please use an ICD-10 code for each service selected**	
☐ OT	ICD-10 Code _____
☐ PT	ICD-10 Code _____
☐ Speech	ICD-10 Code _____
☐ Psych Co*	ICD-10 Code _____
☐ NU**	ICD-10 Code _____

*Psych Co = Psychological Counseling Services
*NU= nursing services (In addition to the prescription, a specific Dr.'s order with detailed instructions is required).

Physician/Physician's Assistant/Nurse Practitioner/SLP Information (**REQUIRED**):
(Please print or use stamp)

Name **(REQUIRED)**:	
Address **(REQUIRED)**:	
Phone # **(REQUIRED)**	
License # **(REQUIRED)**	
NPI # **(REQUIRED)**	
Medicaid # (Optional)	

X_____ **X**_____
Signature of Physician/P.A./Nurse Practitioner/SLP — Date Signed

Must be hand written signature; STAMPED SIGNATURE WILL NOT BE ACCEPTED

Note: Medicaid requires that all services recommended by a Physician, Physician's Assistant, Nurse Practitioner or Licensed Speech Pathologist must be signed **prior to or on** the start date of services.

A FACSIMILE OR PHOTOCOPY OF THIS FORM IS ACCEPTABLE