SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES, DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
PSSHSP REFERRAL FOR EVALUATION OR RECOMMENDATION FOR 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 # _____

Phone # _____

Fax # _____