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

PRESCRIPTION/RECOMMENDATION FOR PRESCHOOL SERVICES

Student's Name: _____ DOB: _____

School/Provider: New Interdisciplinary School 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 **7/1/14 - 6/30/15**

Diagnosis (ICD9 code) REQUIRED

Use an ICD9 codes for each service selected

Service/Therapy (Please check any that apply)	
☐ OT	ICD9 Code _____
☐ PT	ICD9 Code _____

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

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

_____ _____
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 **NIS FAX # 631-924-5687**