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: **Up Wee Grow, Inc.** 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 **7/1/15 - 6/30/16**

Diagnosis (ICD-9 & ICD-10 code) REQUIRED

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

Service/Therapy ** Must use an ICD-9 & ICD-10 code for each service selected		
☐ OT	ICD-9 Code _______________	ICD-10 Code _______________
☐ PT	ICD9 Code _______________	ICD-10 Code _______________
☐ Speech	ICD9 Code _______________	ICD-10 Code _______________
☐ Psych Co*	ICD9 Code _______________	ICD-10 Code _______________
☐ NU**	ICD9 Code _______________	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:
(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