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

Psychological Counseling Referral for Evaluation / Services

A referral for psychological [X] **evaluation** and/or psychological counseling [ ] **services** is recommended in accordance with the request by the Committee on Pre-School Special Education.

Services, when provided, will be in accordance with the Individualized Education Program designed by the Committee.

Student Name: ____

Date of Birth: ____

Provider: ***Up Wee Grow, Inc.***
(Agency, Center based Program or Individual Provider)

District: ____

School Year: ***July 1, 2015 thru June 30, 2016***

X EVALUATION: ____
Reason for Evaluation (Presenting Problem)

☐ SERVICES: ____

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

______________________________ X____
(Please Print Name) **Signature**

________________ ____
Date Signed Title of Authorizing Entity

License Number: ______________ NPI Number: __________________

Medicaid Number: ______________

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

Note: Medicaid requires that psychological evaluations or psychological counseling services be recommended by an appropriate school official, such as a school administrator or chairperson of the CSE/CPSE or other licensed practitioner acting within his or her scope of practice or Physician, Physician's Assistant or Nurse Practitioner on or before the evaluation or start of services.

A FACSIMILE OR PHOTOCOPY OF THIS FORM IS ACCEPTABLE.