**NASSAU COUNTY**

**DEPARTMENT OF HEALTH**

**OFFICE OF CHILDREN WITH SPECIAL NEEDS**

**Preschool Special Education Program**

60 Charles Lindbergh Blvd. Suite 100, Uniondale, New York 11553-3683

***Speech Referral for Evaluation or Recommendation for Services***

***(You must use a separate form for each*.)**

A Speech and Language referral for an **evaluation** or a recommendation for **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Agency, Center based Program or Individual Provider)

District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Period of Service:

School Year: ***July 1, 2014 through June 30, 2015***

□ EVALUATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Evaluation**

(Use the ICD-9 code or describe the Presenting Problem if no diagnosis exists at time of evaluation.)

□ SERVICES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Use official ICD-9 code) REQUIRED - Use as many ICD9 codes as appropriate

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Please Print Name)** **NYS Licensed Speech Pathologist**

Medicaid provider Number**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

**License Number:** \_\_\_\_\_\_\_\_\_\_\_\_ **NPI Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Signed:** \_\_\_\_\_\_\_\_\_\_\_

**Note**: Medicaid requires that speech evaluations and services be recommended by a Licensed Speech Pathologist, Physician, Physician’s Assistant, or Nurse Practitioner **prior to or on** the date of the evaluation or the start of services.

**\*Must be original signature – Stamped Signature will not be accepted.**

A FACSIMILE OR PHOTOCOPY OF THIS RECOMMENDATION IS ACCEPTABLE.