**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

***Referral for Psychological Evaluation or Recommendation***

***for Psychological Counseling Services***

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

A referral for a Psychological **evaluation** or recommendation for Psychological Counseling **services** is 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please Print Name)**

Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicaid**

**License Number:** \_\_\_\_\_\_\_\_\_\_\_\_ **NPI Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Provider #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 CPSE or other licensed practitioner acting within his or her scope of practice, **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.