**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

# Physician Prescription for Evaluations

Based on a review of the child’s records, I am referring this child for the following evaluation(s):

Student’s Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Agency, Center Based School or Individual Provider)

|  |
| --- |
| Type Of Evaluation  (Please check any that apply) |
| Audiological  Neurological  Orthopedic  Psychological  Psychiatric  Occupational Therapy  Physical Therapy  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| \*REQUIRED  Reason for Evaluation  (ICD-9 Code or Presenting Problem) |  |

Physician/Physician’s Assistant/Nurse Practitioner Information

(Please print or use stamp):

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
|  |  |
| Phone Number: |  |
| License # (REQUIRED) |  |
| NPI # (REQUIRED) |  |
| Medicaid Provider # (REQUIRED) |  |

\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician/Physician’s Assistant/Nurse Practitioner Date

**Must be original signature: STAMPED SIGNATURE WILL NOT BE ACCEPTED**

A FACSIMILE OR PHOTOCOPY OF THIS RX IS ACCEPTABLE.