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| Student Name | | | |
| Date of Birth | | | Diagnosis/ICD-10 Code |
| Referral Dates | From | To | Case Manager/Clinician |
| Address | | | |
| Phone Number | | | Email Address |
| District of Liability/Responsible LEA | | | |
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|  | **Service Type** | **Allowable Authorizing Provider** |
|  | Any Service | Physician, Physician Assistant, Nurse Practitioner |
| ⬜ | ABA (Applied Behavior Analysis) Services | Licensed ABA or Licensed Psychologist |
| ⬜ | Audiology | Licensed Audiologist/Hearing Instrument Specialist |
| ⬜ | Dental Assessments/Screenings | Dental Hygienist |
| ⬜ | Mandated/EPSDT Health/Behavioral Health Screenings | All EPSDT screenings and visits meet requirement standard |
| ⬜ | Medical Nutritional Services | Licensed Nutritionist/Dietician |
| ⬜ | Occupational Therapy | Licensed Occupational Therapist |
| ⬜ | Personal Care Services | Physician, Physician Assistant, Nurse Practitioner |
| ⬜ | Physical Therapy | Licensed Physical Therapist |
| ⬜ | Psychological Counseling | LICSW or Licensed Psychologist |
| ⬜ | Skilled Nursing Services/Planned Nursing Services | Physician, Physician Assistant, Nurse Practitioner |
| ⬜ | Speech-Language Therapy | Licensed Speech-Language Pathologist |
| ⬜ | Vision Services | Optometrist |
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| As a physician, physician assistant, nurse practitioner or applicable licensed practitioner of the healing arts practicing within the scope of my practice as indicated above, I order/recommend that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ services be provided to the above-named student in accordance with the determinations made by the student’s IEP team and described in this student's current IEP, pursuant to this student’s Section 504 plan or other health plan, or deemed otherwise medically necessary. The frequency and duration of the ordered service are \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |

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| Provider Signature | | Date |
| Provider Name (Printed) | | |
| Credential | License Number | |
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