Order / Recommendation Referral Form (ORRF)

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			

	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

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 _____.

Provider Signature		Date
Provider Name (Printed)		
Credential		License Number

Revision Date: 07/01/2019