Order/Referral for Related Services

School District: _____

School District address and Phone #: _____

_____

Student's Name _____ Date of Birth _____

Effective from ___/___/___ to ___/___/___

I recommend the above listed student receive the following services:

Service:	Medical Diagnosis for each service Please list ICD-10 Code
Speech/Language Therapy Services as per IEP	_____
Physical Therapy Services as per IEP	_____
Occupational Therapy Services as per IEP	_____
Skilled Nursing Services as per IEP	_____
Psychological Counseling Services as per IEP	_____

Please print
Name and title _____
Contact information (address and phone #)

_____

_____

License Number or NPI Number: _____

Signature: _____ Date: _____
Signature of a NYS licensed and registered physician, a physician assistant, or a licensed nurse practitioner acting within his or her scope of practice (for psychological counseling services this also includes an appropriate school official and for speech therapy services, a speech-language pathologist)

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An Order/Referral for services must be completed for each IEP period. In addition, a new Order/Referral must be completed whenever reviews conducted during an IEP period result in a change in a service.