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 ICD-10 Code	Individual or Group	Frequency	Duration	Cycle
Speech/Language Therapy					
Physical Therapy					
Occupational Therapy					
Psychological Counseling					

Please print Name and title _____

Contact information (Address and Phone Number)

_____

_____

License Number or NPI Number: _____

Signature: _____ 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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A new Order/Referral must be completed whenever reviews conducted result in a change in the service or if there is a new Annual IEP created.

Revised March 9,2026