

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)

<u>Type Of Evaluation</u> (Please check any that apply)					
<input type="checkbox"/> Audiological	<input type="checkbox"/> Neurological	<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Psychological	<input type="checkbox"/> Psychiatric	
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech	<input type="checkbox"/> Other _____		

Note: Please provide an ICD-10 code for each evaluation selected

<b>*REQUIRED</b> Reason for Evaluation (ICD-10 Code or Presenting Problem)	
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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.**