CENTER FOR SPECTRUM SERVICES
Referrals/Physician Orders/Recommendations for SERVICES

Child's Name ________________________________ **Date of Birth** __________________

Effective Dates ______________**through** _______________

Regarding ICD codes:
- **Script is not valid without an ICD 10 Code.**
- **You must provide the MOST SPECIFIC ICD 10 CODE possible for each service.**

_____**Speech Therapy**	**ICD-10 Code**	_ _ _. _ _
_____**Occupational Therapy**	**ICD-10 Code**	_ _ _ ._ _
_____**Physical Therapy**	**ICD-10 Code**	_ _ _ ._ _
_____**Skilled Nursing***	**ICD-10 Code**	_ _ _ ._ _
_____**Psychological Counseling**	**ICD-10 Code**	_ _ _. _ _

Reason__________________________ ______________________________________

**~Skilled Nursing Services require specific physician's order with specific instructions~*

I, in my professional opinion, recommend that the above child be provided with the following medically necessary service(s) in accordance with the frequency, duration, and service delivery method (individual and/or group w/ ratio) as recorded on the child's Individualized Education Plan (IEP) for the time period indicated above.

X____ ________________ ________________
(Original Signature of Physician, Physician Assistant, or Nurse Practitioner,) (Title) (Signature Date) (Mm/dd/yy format)

Note: Referrals for Speech Evaluation or Services may be made a Speech Language Pathologist who has seen the child; Referrals for psychological counseling services may be made by an appropriate school official, such as a school administrator or the chairperson of the CSE/CPSE, or a licensed practitioner acting within his/her scope of practice).

Name ____ ***NYS License No.*** ______________________
Print First & Last Name)

Address ____***NPI No.*** ____________________________

________________________________ ***Provider Medicaid #***_________________________

Phone #___________________________________ **Fax #**_________________________________

Office Stamp

ORIGINALS ARE REQUIRED. PLEASE RETURN/MAIL FORM WITH ORIGINAL SIGNATURES TO THE ADDRESS BELOW. THANK YOU

RETURN TO: **Center for Spectrum Services**

70 Kukuk Lane, Kingston NY 12401

Phone # (845) 336-2616 Fax # (845) 336-4153