45 YEARS
CENTER FOR SPECTRUM SERVICES
Brightening the lives of people with autism

70 Kukuk Lane
Kingston, NY 12401
tel: 845.336.2616
fax: 845.336.4153

4 Yankee Place
Ellenville, NY 12428
tel: 845.647.6464
fax: 845.647.3456

Susan Buckler Executive Director Charlotte Mennona Program Director
web: www.centerforspectrumservices.org

## REFERRAL FOR EVALUATION OR RECOMMENDATION FOR SERVICES

In accordance with the request by the Committee of Special Education, a referral for evaluation and/or a recommendation for services as noted below will be provided as specified in the Individualized Education Program (IEP) designed by the Committee.

☐ **Evaluation** ☒ **Services**

**Student Name** _____ **DOB** _____

**District** _____ **County** _____

**Agency** **Center for Spectrum Services (Kingston Location)** **(845) 336-2616**
(Name of Agency, Center-based Program or Individual Provider / Phone)

(Check One)
**Reason for Rx:** ☐ **Annual Review Meeting** ☐ **Change in Service** ☐ **Transfer Meeting** ☐ **Re-Eval Meeting** ☒ **New Referral**

**TERM OF SERVICE: 07/04/2022 – 06/23/2023**
**(Services to be delivered as per the IEP)**

| TYPE OF SERVICE | (REQUIRED) ICD CODE for SERVICE(S) | Medical Diagnosis/Purpose of Treatment |
|---|---|---|
| Occupational Therapy ⇨ | | |
| Physical Therapy ⇨ | | |
| Speech ⇨ | | |
| Psychological Counseling ⇨ | | |
| Skilled Nursing **(Requires a Physician's Order)** | | |

*Suggested* ICD 10 codes F84.0 F82. R62.0 R62.50

**** An** order/referral for services must be completed for each IEP period.*
*A new order/referral must be completed whenever reviews conducted during an IEP period results in a change in service (i.e., frequency/duration/Inv-Grp).*

**Signature** _____ **Date Signed** _____
**(Original Signature Required – Stamps Not Permitted)** **(Required)**

**Print Name** _____ **Title** _____

**(REQUIRED / STAMP ACCEPTED)**
**Address**

**Phone**

**(REQUIRED)** **License #** _____

**(REQUIRED)** **NPI #** _____

Medicaid # _____

Fax # _____

**Please fax a copy of the script to (845) 215-0497**
**Mail the original to 70 Kukuk Lane, Kingston NY 12401**