PRESCRIPTION FOR SCHOOL-BASED RELATED SERVICES

Student's Name: ____ DOB: ________

School District: ____

The child named above is recommended for the following service(s) in accordance with the frequency and duration indicated on the Individualized Education Program (IEP).

Period of Service: 7/1/17 - 6/30/18

Service/Therapy

Check all that apply. Indicate Diagnosis ICD Code.

- [ ] Occupational Therapy — ICD10 Code ________
- [ ] Physical Therapy — ICD10 Code ________
- [ ] Psychological Counseling — ICD10 Code ________
- [ ] Skilled Nursing — ICD10 Code ________
- [ ] Speech Therapy — ICD10 Code ________
- [ ] Therapeutic Feeding — ICD10 Code ________
- [ ] Reevaluation

Physician/Physician's Assistant/Nurse Practitioner Information

REQUIRED INFORMATION

	Physician's Stamp
Name:	
Address:	
Phone #:	
License #:	
NPI #:	

____ ________

Signature of Physician/Physician's Assistant/Nurse Practitioner — Date

Must be original signature; STAMPED SIGNATURE WILL NOT BE ACCEPTED.
ICD Code and NPI # Mandatory.

All information MUST be completed in order for Prescription to be valid.

A facsimile or photocopy of this Rx is acceptable.