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

Referral for Psychological Evaluation or Recommendation for Psychological Counseling Services

(You must use a separate form for each.)

A referral for a ☐ Psychological **evaluation** or recommendation ☐ for Psychological Counseling **services** is in accordance with the request by the Committee on Pre-School Special Education.

Services, when provided, will be in accordance with the Individualized Education Program designed by the Committee.

Student Name: _____

Date of Birth: _____

Provider: _____
(Agency, Center based Program or Individual Provider)

District: _____

Period of Service: School Year: ***July 1, 2024 thru June 30, 2025***

☐ EVALUATION

Reason for Evaluation _____
REQUIRED - Use official ICD-10 code for all Evaluations. Use as many ICD-10 codes as appropriate or describe the Presenting Problem if no diagnosis exists at time of evaluation.

☐ SERVICES: _____
REQUIRED - Use official ICD-10 code for all services. Use as many ICD-10 codes as appropriate.

**_____ *Signature: _____
(Please Print Name)

****Title:** _____ **DATE: _____

****ADDRESS:** _____

****PHONE NUMBER:** _____

****LICENSE NUMBER:** _____ **NPI NUMBER:** _____ ****MEDICAID PROVIDER #**_____

Note: Medicaid requires that psychological evaluations or psychological counseling services be recommended by an appropriate school official, such as a school administrator or chairperson of the CPSE or other licensed practitioner acting within his or her scope of practice, **prior to or on** the date of the evaluation or the start of services.

***Must be original signature – Stamped Signature will not be accepted.** ****Required Information**

A FACSIMILE OR PHOTOCOPY OF THIS RECOMMENDATION IS ACCEPTABLE.

January 2024 Revised