**PRESCRIPTION FOR EARLY INTERVENTION THERAPEUTIC SERVICES**

 **Child’s Name: DOB:**

 **Doctor’s Name: Dr. Fax:**

 **Child’s IFSP Date:**

Based on review of the evaluation reports and/or progress reports, it is recommended that the above named child receive the following therapy. In order to provide this service, we need a current prescription. We have parental consent on file for you to release medical information to us.

Please indicate if there are any medical limitations

□ There are no restrictions/ contra-indications □ There are restrictions (attach medical clearance)

**EARLY INTERVENTION SERVICES/THERAPY FREQUENCY**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Per IFSP

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Per IFSP

Script is valid for any IFSP frequency/duration recommendation written within one year of date signed

**Diagnosis (ICD-10 code) REQUIRED**

**You must provide the MOST SPECIFIC ICD CODE(S) for each service checked.**

|  |
| --- |
| Service/TherapyMust use an ICD-10 code for each service selected |
| [ ]  OT ICD-10 Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  PT ICD-10 Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Speech ICD-10 Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*\*Please have Rx signed by a Medicaid enrolled Physician, PA or NA if possible per NYS Dept. of Health**

**Physician/Nurse Practitioner/PA Information: (Please print or use stamp.)**

Name:

Address:

Phone Number:

License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid Provider #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Physician/Nurse Practitioner/PA Signature**: Date \_\_\_\_\_\_\_\_\_\_

**(Must be original signature)**