**PRESCRIPTION FOR EARLY INTERVENTION THERAPEUTIC SERVICES**

**Child’s Name: DOB:**

**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. Please have your physician complete this form and return it to us. **If you would like us to obtain these records directly from your** **physician**, please complete the enclosed medical release form and return it to our office.

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/Therapy  Must specify 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 NP if possible per NYS Dept. of Health**

**Physician/Nurse Practitioner Information:**

Name:

Address:

Phone Number:

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

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

**(Must be original signature)**