PRESCRIPTION FOR SCHOOL-BASED RELATED SERVICES

Student's Name: _____ DOB:_____

School District: _____

The child names 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: 7/1/22-6/30/23

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

Name:	Physician's Stamp
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