Onondaga Central School District

Office of Preschool Special Education
208 Rockwell Road, Nedrow, NY 13120-1010
(315) 552-5078 • (315) 552-5076 Fax

WRITTEN ORDER / REFERRAL / PRESCRIPTION

Name of Student: _____ **Date of Birth:** _____

The student named above has been recommended for the following service(s). ***Select EITHER:***

☐ **EVALUATION** **or** ☑ **SERVICE / THERAPY (as per IEP)**

Evaluation Type(s)	**Service/Therapy Type(s)**	**Period of Service** *FILL IN (i.e. 7/1/17 – 6/30/18)*
____ Audiological	____ Audiological	_____
____ Speech [A]	____ Speech [A]	_____
____ Occupational Therapy	____ Occupational Therapy	_____
____ Physical Therapy	____ Physical Therapy	_____
____ Other:	____ Other:	_____

[A] A licensed, registered Speech Language Pathologist can authorize a speech written order/referral.

Physician/ Physician Assistant/ Nurse Practitioner [C]/ SLP [A]/ School Official [B] *(**PRINT or Stamp ALL information**):*

Name: , MD PA NP	
Address:	
Phone Number:	
NPI #:	

[C] A Nurse Practitioner diagnosis must abide by NYS Education Law §6902(3)(a) scope of practice.

ICD-10 DIAGNOSIS for ordered service / PRECAUTIONS *(must be filled out by prescribing provider):*

_____ _____
Signature of Prescribing Provider* Date*
(must be ORIGINAL signature) ***(must be dated)***

**** STAMPED Signature or STAMPED Date will NOT be accepted ****

Facsimile or photocopy of this completed and signed written order/Rx is acceptable

Please Mail or Fax to: ONONDAGA CSD – Preschool Special Education Office (315) 552-5076