



Psychological Counseling Referral for Evaluation/Services

A psychological counseling referral for an [] **evaluation** and/or [**X**] **services** is recommended in accordance with the request by the Committee on Preschool School Special Education.

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

Evaluation/Services recommended for: _____
mm/dd/yyyy-mm/dd/yyyy

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

School District: _____

Provider: TheraCare
(Service Provider Agency)

Address: 1133 Westchester Ave., Suite N-230
White Plains, NY 10604

Phone: (914) 576-5292

ICD-10 (must be most specific code available): _____

Purpose of Treatment or Evaluation: _____

(Print Name) X _____
(Signature)

Contact information for Psychologist:

Full Address

Phone Number

LICENSE NUMBER: _____ **DATE SIGNED:** _____

NPI # : _____
(Licensed Psychologists)

Note: Medicaid requires that counseling evaluations be recommended by one of the following: 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, on or before the evaluation or start of services (Licensed Psychologist; LCSW)