TheraCare

Speech Referral / Recommendation for Evaluation/Services

A Speech and Language 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 frequency and duration listed within the Education Program designed by the Committee. Any changes made to the frequency and/or duration in the IEP requires a new referral.

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

School District: _____ **School Year: _____**
mm/dd/yyyy – mm/dd/yyyy

Provider: __TheraCare____
(Service Provider Agency)
Address: 1133 Westchester Ave., Suite N-230 **Phone: (914) 576-5292**
White Plains, NY 10604

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

Purpose of Treatment or Evaluation: _____

_____ X_____
Please Print SLP Name Signature- Must be NYS Licensed SLP/ASHA certified

Contact information for SLP:

_____
Full Address

_____
Phone Number

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

NPI NUMBER:_____

Note: Medicaid requires that speech evaluations and services be recommended by a **Licensed Speech Pathologist**, Physician, Physician's Assistant or Nurse Practitioner **prior to or on** the date of the evaluation or the start of services.

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