



Prescription Form

Please complete **the entire form**, including the **ICD-10 Codes**. The Board of Education **requires** **all** this information.

If you have any questions, please contact:

Iris M. Pagan @ 718-454-6460 Ext. 14

Doctor, Nurse Practitioner or Physician Assistant **Order for School Health Related Support Services**

Student Name: _____
First Last

Birth Date: _____ / _____ / _____ NYC Student ID: _____
Month Day Year OSIS #

I have reviewed the recommendations on the student's IEP with respect to the therapies below and in my opinion, the following services are deemed medically necessary:

for each therapy on the student's IEP, mark one column and include ICD Code(s)

		Service IS Medically Necessary	Service, as written, IS NOT Medically Necessary	ICD Code(s) associated with each service
please blacken a circle only for services on the IEP	Occupational Therapy	<input type="radio"/>	<input type="radio"/>	
	Physical Therapy	<input type="radio"/>	<input type="radio"/>	

Ordering Doctor, PA or NP's Signature (an original signature is required)

Date

Ordering Doctor, PA or NP's Name

Ordering Doctor, PA or NP's License Number

Address (Street)

Ordering Doctor, PA or NP's NPI Number

Address (City, State, ZIP)

Ordering Doctor, PA or NP's Medicaid Provider ID Number

Telephone Number