NEW HARTFORD CENTRAL SCHOOL DISTRICT

Please return to:

Therapist_____ Fax_____

PRESCRIPTION FOR RELATED THERAPY SERVICES

Effective dates: July 1, _____ to August 30_____

Student Name: _____ DOB: _____

The above student is recommended to receive school-based therapy from a licensed or registered therapist. The reason for the prescription is to enhance the student's academic performance and promote independent function in the educational setting due to a disability in the area(s) of_____

To be completed by therapist(s)

Recommended Services:

Therapy	Include- Frequency x Minutes and Weekly or # Cycle	Individual Sessions	Group Sessions	Frequency/Cycle Summer	Individual SUMMER	Group SUMMER

↓TO BE COMPLETED BY PHYSICIAN OR Service Provider↓

The above named child is a student from the New Hartford Central School District and the Committee on Special Education has recommended the above therapies. If you agree with this recommendation, please complete and return this form. Please note that no services can be provided until this script is signed and returned.

*ICD 10 Code(s): _____ SCRIPT IS NOT VALID WITHOUT CODES**

Office Phone:_____ Office Fax: _____

Physician's/ Therapist's Contact Information (Office stamp or pre-printed information)	
Physician's/Therapist's NPI #:	
Original Signature:	Date:

Frequency and duration of services as per IEP