NEW YORK SCHOOL FOR THE DEAF

555 KNOLLWOOD ROAD
WHITE PLAINS, NEW YORK 10603

(914) 949-7310 (V)

PRESCRIPTION FOR **OCCUPATIONAL/PHYSICAL** THERAPY SERVICES

Student Name________________________ **Date of Birth**______________________________
Disability: Deafness

I recommend that this student receive Occupational and or Physical Therapy in accordance with the frequency and duration indicated on the Individualized Education Program (IEP).

Related Service	**Frequency** **Indicate Indiv or Grp**	**Duration**	**Period**	**Time Frame**
Occupational Therapy				
Physical Therapy				

ICD-10 CODE (S)

☐ 315.9 (unspecified delay in development)

☐ Other: Please specify_______________

Notes:
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Physician's Signature________________________________Date: ________________________________

Contact Information:
Please print

Physician's Name____

NPI#________________________License#____________________Medicaid#______________

Address: ____

City, State, Zip____

Telephone: _________________________________Fax: ________________________________