FORM D

Office of Special Education, Central Registration &
Pupil Personnel Services
501 Route 110, Amityville, NY 11701

Psychological Counseling Referral for Evaluation/Services

A referral for psychological ☐ **evaluation** and/or psychological counseling ☐ **services** is recommended in accordance with the request by the Committee on Special Education.

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

Student Name: _____

Date of Birth: _____

School District: _____

DIAGNOSIS / ICD9 Codes/
or Purpose of Treatment or Evaluation _____

_____

_____ _____
Print Name and Title Signature (**Must be original signature)**

License Number (if applicable): _____

_____ Date Signed: _____
Title

Note: Medicaid requires that psychological counseling services be recommended by an appropriate school official, such as a school administrator or chairperson of the CSE or other licensed practitioner acting within his or her scope of practice, on or before the start of services.