

District of Liability: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Ohio Prescription/Recommendation Form**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Current IEP Dates - From: \_\_\_\_\_ To: \_\_\_\_\_

**RECOMMENDATION FOR SPEECH/LANGUAGE SERVICES:**

<input type="checkbox"/>	Initial Recommendation	<input type="checkbox"/>	Review: Based on therapy sessions and ongoing evaluation of the student's needs, therapy services should continue as agreed upon with the IEP team.
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As a licensed speech-language pathologist, practicing within the scope of my practice under Ohio law, I recommend that speech-language services be provided to the above student in accordance with the determinations made by the IEP team and described in this student's current IEP.

Signature: \_\_\_\_\_ Credential: \_\_\_\_\_ Date: \_\_\_\_\_

**RECOMMENDATION FOR OCCUPATIONAL THERAPY SERVICES:**

<input type="checkbox"/>	Initial Recommendation	<input type="checkbox"/>	Review: Based on therapy sessions and ongoing evaluation of the student's needs, therapy services should continue as agreed upon with the IEP team.
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As a licensed occupational therapist, practicing within the scope of my practice under Ohio law, I recommend that occupational therapy services be provided to the above student in accordance with the determinations made by the IEP team and described in this student's current IEP.

Signature: \_\_\_\_\_ Credential: \_\_\_\_\_ Date: \_\_\_\_\_

**RECOMMENDATION FOR PHYSICAL THERAPY SERVICES:**

<input type="checkbox"/>	Initial Recommendation	<input type="checkbox"/>	Review: Based on therapy sessions and ongoing evaluation of the student's needs, therapy services should continue as agreed upon with the IEP team.
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As a licensed physical therapist, practicing within the scope of my practice under Ohio law, I recommend that physical therapy services be provided to the above student in accordance with the determinations made by the IEP team and described in this student's current IEP.

Signature: \_\_\_\_\_ Credential: \_\_\_\_\_ Date: \_\_\_\_\_

**RECOMMENDATION FOR AUDIOLOGY SERVICES:**

<input type="checkbox"/>	Initial Recommendation	<input type="checkbox"/>	Review: Based on therapy sessions and ongoing evaluation of the student's needs, therapy services should continue as agreed upon with the IEP team.
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As a licensed audiologist acting within the scope of my practice under Ohio law, I recommend that audiology services be provided to the above student in accordance with the determinations made by the IEP team and described in this student's current IEP.

Signature: \_\_\_\_\_ Credential: \_\_\_\_\_ Date: \_\_\_\_\_

**PRESCRIPTION FOR NURSING SERVICES:**

<input type="checkbox"/>	Initial Recommendation	<input type="checkbox"/>	Review: Based on therapy sessions and ongoing evaluation of the student's needs, therapy services should continue as agreed upon with the IEP team.
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As a physician (M.D. or D.O.), podiatrist, dentist or advanced practice nurse practicing within the scope of my practice under Ohio law, I prescribe that nursing services be provided to the above student in accordance with the determinations made by the IEP team and described in this student's current IEP.

Signature: \_\_\_\_\_ Credential: \_\_\_\_\_ Date: \_\_\_\_\_

**RECOMMENDATION FOR COUNSELING SERVICES:**

<input type="checkbox"/>	Initial Recommendation	<input type="checkbox"/>	Review: Based on therapy sessions and ongoing evaluation of the student's needs, therapy services should continue as agreed upon with the IEP team.
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As a licensed counselor, practicing within the scope of my practice under Ohio law, I recommend that counseling services be provided to the above student in accordance with the determinations made by the IEP team and described in this student's current IEP.

Signature: \_\_\_\_\_ Credential: \_\_\_\_\_ Date: \_\_\_\_\_