EASTER SEALS DUPAGE & FOX VALLEY – PRESCRIPTION FOR Speech-Language and Assistive Technology Services – (Please select all that apply)

CLIENT NAME: _____ Date of Birth: _____

PRESCRIPTION DATES: _____ PRESCRIBED SERVICE(S): __ ST __ AT __ OTHER _____

F00-F99 Mental, Behavioral and Neurodevelopmental Disorders

__ F80.0 Phonological disorder, functional articulation disorder, Dyslalia, lalling, lisping
__ F80.1 Expressive Language Disorder
__ F80.2 Mixed Expressive-Receptive Language Disorder
__ H93.25 Central Auditory Processing Disorder
__ F80.4 Speech & language developmental delay due to hearing Loss; Indicate type of hearing loss_____ Left ear/Right ear/bilateral
__ F80.81 Childhood onset fluency disorder
__ F80.89 Other developmental disorders of speech/ language (semantic, pragmatic, NEC)
__ F80.9 Developmental disorder of speech and language, unspec.
__ F84.0 Autistic Disorder
__ F84.2 Rett's syndrome
__ F84.5 Asperger's syndrome
__ F84.8 Other pervasive developmental disorders
__ F84.9 Pervasive developmental disorder, unspecified
__ F88 Other disorders of psychological development
__ F90.__ Attention Deficit Disorder – MUST SPECIFY
- With hyperactivity/without hyperactivity
- Primarily inattentive component/primarily activity component/mixed

__ F94.0 Selective Mutism

G00-G99 Diseases of the Nervous System

G40. __Epilepsy and recurrent seizures
__ Focal/partial with simple partial seizures – MUST SPECIFY:
- Idiopathic/symptomatic
- Intractable/not intractable
- With status epileptcus/without status epilepticus

__ Focal/partial w/ complex partial seizures– MUST SPECIFY:
- Idiopathic/symptomatic
- Intractable/not intractable
- With status epileptcus/without status epilepticus

__ Generalized idiopathic – MUST SPECIFY:
- Intractable/not intractable
- With status epileptcus/without status epilepticus

__ Other generalized epilepsy & epileptic syndromes- MUST SPECIFY
- Intractable/not intractable
- With status epileptcus/without status epilepticus

Primary disorders of muscles
__ G71.0 Muscular dystrophy
__ G71.11 Myotonic muscular dystrophy
__ G71.12 Myotonia congenita
__ G71.19 Other specified myotonic disorders
__ G71.2 Congenital myopathies
__ G71.3 Mitochondrial myopathy, not elsewhere classified
Cerebral palsy (select below):
__ G80.0 Spastic quadriplegic cerebral palsy
__ G80.1 Spastic diplegic cerebral palsy
__ G80.2 Spastic hemiplegic cerebral palsy– MUST SPECIFY:
- Left/Right and dominant/non-dominant

__ G80.3 Athetoid cerebral palsy
__ G80.4 Ataxic cerebral palsy
__ G80.8 Other cerebral palsy (includes hypotonic cp)
__ G80.9 Cerebral palsy, unspecified

H60-H995 Diseases of the ear and mastoid process

__ H90.__ hearing loss – MUST SPECIFY – CIRCLE ALL THAT APPLY:
- CONDUCTIVE/SENSORINEURAL/MIXED
- EXTERNAL EAR/MIDDLE EAR/INNER
- LEFT/RIGHT/BILATERAL

J00-J99 Diseases of the Respiratory System

__ J38.2 Nodules of vocal cords
__ J69.0 Pneumonitis due to inhalation of food and vomit

M00-M99 Diseases of the musculoskeletal system & connective Tissue

__M26.__Anomaly of jaw size – PLEASE DESCRIBE:
- Maxillary/mandibular/macrogenia/microgenia/tuberosity/ jaw-cranial base
- Asymmetry/maloclussion/open bite/overbite, etc.:

_____

Q00-Q99 Congenital malformations, deformations, and chromosomal abnormalities

__Q02 Microcephaly
Congenital Hydrocephalus or malformations
__ Q03.0 Malformations of aqueduct of Sylvius
__ Q03.1 Atresia of foramina of Magendie & Luschka
__ Q03.9 Congenital hydrocephalus, unspecified
__ Q04.0 Congenital malformations of corpus callosum
__ Q04.1 Arhinencephaly
__ Q04.2 Holoprosencephaly
__ Q04.3 Other reduction deformities of brain
__ Q04.5 Megalencephaly
__ Q04.6 Congenital cerebral cysts
__ Q04._ Other congenital malformations of brain – specify:
_____
Spina Bifida
__ Q05.__ Spina Bifida – CIRCLE DESCRIPTORS
- cervical/thoracic/lumbar/sacral
- hydrocephalus/no hydrocephalus

__ Q31.0 Laryngocele
Cleft Lip and Palate
__ Q35.0 __ Cleft Palate – MUST SPECIFY: hard/soft/both/uvula
__ Q36.0_ _ Cleft Lip – MUST SPECIFY: bilateral/unilateral/median
__ Q37.0_ Cleft Lip and Palate – MUST SPECIFY: hard/soft palate/both bilateral/unilateral lip
__ Q38.1 Ankyloglossia, Tongue Tie
__ Q38.3 Other cong. Malformations of tongue (includes tongue thrust)
__ Other congenital musculoskeletal deformity – MUST SPECIFY:
_____
Trisomy:
__Q90.1 Trisomy21, nonmosaicism
__Q90.2 Trisomy 21, translocation
__Q90.9 Down syndrome, unspecified
__ Q91.__ Trisomy 18 – SPECIFY: Nonmosaicism/ mosaicism /translocation/unspecified

__ Q91.__ Trisomy 13 – SPECIFY: Nonmosaicism/ mosaicism /translocation/unspecified

__ Q92__ Other and partial trisomies of the autosomes, not elsewhere classified (must describe):
_____
__Q99.__ Other chromosomal abnormality – MUST SPECIFY:
_____

R00-S99 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified

__ R13.__ Dysphagia – MUST SPECIFY PHASE: Oral/oralpharyngeal/pharyngeal/pharyngoesophageal
__ R27.8 Other lack of coordination (incoordination)
__ R29.810 Facial weakness, droop (not Bell's Palsy)
__ R41.844 Frontal lobe and executive function deficit
__ R47.01 Aphasia
__ R47.1 Dysarthria and anarthria
__ R47.81 Slurred speech
__ R47.89 Other speech disturbances
__ R48.2 Apraxia
__ R48.8 Other Symbolic Dysfunctions
__ R49.0 Dysphonia, Hoarseness
__ R49.1 Aphonia, Loss of voice
__ R49.21 Hypernasality
__ R49.22 Hyponasality
__ R49.8 Other voice and resonance disorders
__ R62.0 Delayed milestone in childhood (0-17 years only)
__R62.50 Unspecified lack of normal physiological development in childhood (0-17 years only)
__R62.51 Failure to thrive (child) (failure to gain weight; less than normal growth)
__R63.3 Feeding Difficulties
__K21.0 Gastro-esophageal reflux with esophagitis
__ K21.0 Gastro-esophageal reflux without esophagitis

OTHER – BE SPECIFIC: _____
OTHER – BE SPECIFIC: _____
OTHER – BE SPECIFIC: _____

I certify that these prescribed services are medically necessary.

__ Provide/Continue to provide services per plan of care. Adhere to the following Precautions:
_____
__ Revise Plan of Care as follows:
_____

__ Discontinue services.

PHYSICIAN'S SIGNATURE:

_____

DATE:_____

PHYSICIAN NAME:
ADDRESS:
CITY/STATE/ZIP:
PHONE:
FAX: