Sumlar Therapy Services, Inc.

Pediatric Physical Therapy, Occupational Therapy, and Speech Therapy
With Hippotherapy and Aquatic Therapy

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NEW THERAPY REFERRAL

To be completed by School Representative:

Date of Referral: _____

Name of School: _____ **School Representative:** _____

Check One: ☐ Physical Therapy ☐ Occupational Therapy

Speech Therapy: ☐ Articulation ☐ Stuttering ☐ Language ☐ Other

IEP Holder: _____ **Email:** _____

Note: Prescription or Medicaid Referral is NOT REQUIRED.

To be completed by Parent or Guardian:

Name:	
DOB:	**Diagnosis if known:**
Parents'/Guardian's Name:	
Home Street Address:	
City, State Zip Code:	
Phone Number(s) (home/cell/work)**:**	
Alternate Phone Numbers:	
Physician:	**Physician's phone #:**

Parent/Legal Guardian Signature Required:

Authorization for Evaluation and Provision of Services: The undersigned hereby authorizes Sumlar Therapy Services, Inc., (referred to as "Provider") to render to the student physical therapy, occupational therapy, and/or speech therapy as indicated by this school system referral and to provide per the recommendations as put forth by the IEP team.

Release of Information: The undersigned hereby certifies that all information provided to the Provider by the undersigned is true and accurate in in all respects; authorizes Provider to disclose any information, medical or non-medical, furnished to or obtained by Provider in connection with student's diagnosis and/or treatment to any physician, government agency, (including the U.S. Department of Health and Human Services,or any of its intermediaries or carriers), insurance company or health care provider requesting such information; agrees to allow Provider access to patient medical records and agrees to allow Provider to make copies of such records; consents to the discussing by Provider of the student's medical condition with student's family members and/or school representatives.

Signed: _____ **Date:** _____