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:

Name of School: ______________________ **School Repesentative:** ______________________
Date of Referral: ______________________

Check One: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Prescription from physican is required for Physical Therapy only

Your Checklist: A referral **must** include this completed form and the following:

☐ If PT is selected, a prescription for for PT (in traditional format) is required with this referral.

☐ If homebound or daycare, please provide **directions** here:

To be completed by Parent or Guardian:

Name:		
DOB:	**Diagnosis if known:**	
Parents'/Guardian's Name		
Home Address:		
Phone Number(s) (home/cell/work)**:**		

Physician:		**Physician's phone #:**
Is your child covered by Medicaid?	YES ( )	NO ( )

All Parents Please Sign:

Authorization for Treatment: The undersigned hereby authorizes Sumlar Therapy Services, Inc., (referred to as "Provider") to render to the patient physical therapy, occupational therapy, and/or speech therapy that the Provider and/or patient's physician determine to be necessary and advisable.

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 patient'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 patient's medical condition with patient's family members for medical or claims management purposes.

Signed: ______________________ **Date:** ______________