Sumlar Therapy Services, Inc.

School Physical Therapy and Occupational Therapy

Phone (334) 445-6336
email@sumlartherapy.com
www.sumlartherapy.com

***Please email completed referral to our office*:**
email@sumlartherapy.com

For office use only
INITIAL CODE: DATE REC'D:

NEW SCHOOL THERAPY REFERRAL: Page 1

TO BE COMPLETED BY SCHOOL:

Today's Date: _____ / _____ / _____

School: _____ **School System:** _____

School Representative Name: _____ **Signature:** _____

☐ **IEP** ☐ **Pending IEP** **Case Manager's Email:** _____

☐ **504** ☐ **Pending 504** (Therapy reports will be emailed to this individual. Reports will be cc'd to others only per your coordinator's request.)

Student Name: _____ **DOB:** _____ / _____ / _____

Allergies, Precautions: _____

Grade: _____ **Repeated Grade:** _____ **Teacher(s):** _____

☐ **Pre-K** ☐ Currently Attending
☐ Not Currently Attending
Start Date: _____

Schedule or Additional INFO: _____
_____

- Select only therapy discipline(s) for which **Sumlar Therapy** is your school's provider. A physician's prescription or Medicaid referral is NOT required. Check with your coordinator for additional therapy referral process considerations.
- If the selected therapy is already on the incoming student's IEP or 504, please include the current/adopted IEP or 504 listing PT or OT with your referral today. Commensurate services will be considered.
- Select Physical and/or Occupational Therapy below. Describe concerns observed in the educational environment. Referrals that do not contain educationally relevant concerns may be returned to submitter with request for additional information.
- Complete Referrals must contain Page 1 (*completed and signed by school representative*) and Page 2 (*completed and signed by the parent*). There is a Spanish version of Page 2, following the English version, on an additional page in this document.
- Scan the completed two-page referral into a **SINGLE document/PDF** and email to: **email@sumlartherapy.com.** Photos will not be accepted. Referrals are maintained in our student records.

☐ **PHYSICAL THERAPY** Examples: student has difficulties with: getting up and down from the floor; sitting in a classroom chair; accessing the bathroom or playground; walking in hallway or on bus; going up and down steps; participating in PE**.**

***Describe your concerns in the educational environment:** _____

_____

_____

☐ **OCCUPATIONAL THERAPY** Examples: student has difficulties with: using zippers or buttons; opening food containers; using a crayon or pencil; copying from the board; regulating sensory input or response; visually scanning pages**.**

***Describe your concerns in the educational environment:** _____

_____

_____

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NEW SCHOOL THERAPY REFERRAL: Page 2

*****Please note: A prescription or Medicaid referral is *NOT* required.*****

TO BE COMPLETED BY PARENT/GUARDIAN and returned to the school:

STUDENT Name: _____

DOB: _____ / _____ / _____ ☐ **Male** ☐ **Female** **Grade:** _____

Diagnosis: _____

Allergies, Precautions: _____

Concerns for Therapy: _____

_____

Parent/Guardian Name(s): _____

Home Street Address: _____

City, State, Zip: _____

Phone Number(s): _____

Email: _____

Pediatrician's Name: _____ 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 designated in the IEP or Section 504 document(s) as provided to Provider upon referral or following referral. **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 medical providers, student's family members and/or school representatives.

Parent/Legal Guardian SIGNATURE: _____ **Date:** _____ / _____ / _____

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REMISIÓN DE TERAPIA DE NUEVA ESCUELA: Página 2

***** Tenga en cuenta: NO se requiere una receta o referencia de Medicaid.*****

PARA SER COMPLETADO POR EL PADRE/TUTOR y devuélvala a la escuela:

Nombre del ESTUDIANTE: _____

Fecha de Nacimiento: _____ / _____ / _____ ☐ **Masculino** ☐ **Femenina** **Calificación:** _____

Diagnóstico: _____

Alergias, Precauciones: _____

Preocupaciones para terapia: _____

_____

Nombre(s) de padre/tutor: _____

Dirección de la calle de la casa: _____

Ciudad, Estado, Código postal: _____

Número(s) de teléfono: _____

Correo electrónico: _____

Nombre del pediatra: _____ Número de teléfono: _____

Se requiere la firma del padre/tutor legal:

Autorización para la evaluación y prestación de servicios: El firmante de abajo autoriza a Sumlar Therapy Services, Inc., (denominado "Proveedor") a prestar al estudiante terapia física, terapia ocupacional y / o terapia de habla según lo indicado por esta referencia del sistema escolar y a proporcionar según las recomendaciones designadas en el IEP o en los documentos de la Sección 504 proporcionados al Proveedor al momento de la remisión o después de la referencia. **Divulgación de información:** El abajo firmante certifica que toda la información proporcionada al Proveedor por el firmante de abajo es verdadera y precisa en todos los aspectos; autoriza al Proveedor a divulgar cualquier información, médica o no médica, proporcionada u obtenida por el Proveedor en relación con el diagnóstico y/o tratamiento del estudiante a cualquier médico, agencia gubernamental (incluido el Departamento de Salud y Servicios Humanos de los Estados Unidos, o cualquiera de sus intermediarios o transportistas), compañía de seguros o proveedor de atención médica que solicite dicha información; acepta permitir que el Proveedor tenga acceso a los registros médicos de los pacientes y acepta permitir que el Proveedor haga copias de dichos registros; consiente que el Proveedor discuta la condición médica del estudiante con los proveedores médicos del estudiante, los miembros de la familia del estudiante y / o representantes de la escuela.

FIRMA del padre/tutor legal: _____ **Fecha:** _____ / _____ / _____