



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: <input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy
IEP Holder: _____	Email: _____	
If <u>homebound</u> or <u>daycare</u> , please provide directions here:		
<i>Note: Prescription or Medicaid Referral is no longer required to complete this referral.</i>		

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 #: _____
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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 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:** _____