Sumlar Therapy Services, Inc.

….helping, healing, loving, and believing

193 Sam Lisenby Road
Ozark, AL 36360
Phone (334) 445-6336
Fax (334) 445-6363
email@sumlartherapy.com
www.sumlartherapy.com

***Please email or fax completed referral to our office*:**
email@sumlartherapy.com
Fax (334) 445-6363

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

NEW SCHOOL THERAPY REFERRAL: Page 1

TO BE COMPLETED BY SCHOOL: **Date:** _____ / _____ / _____

School: _____ **School System:** _____

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

☐ **IEP** ☐ **504** **Case Manager's Email:** _____
(report sent here)

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

Grade: _____ **Repeated Grade:** _____ ☐ **Pre-K** **Teacher(s)**: _____

☐ **Check this box** if Information is being completed by an authorized school representative in the instance of a contract referral where an agreement exists between Sumlar Therapy Services, Inc. and the school system making multiple referrals. By signing above, the school representative is agreeing to the Authorization for Evaluation and Provision of Services in absence of parent signature, and is providing the student's information to the best of their knowledge.

Please Read
- **Select only disciplines for which Sumlar Therapy is your school provider.**
- **If the selected therapy is already on the student's IEP, please include the current IEP with your referral today.**

☐ **Physical Therapy** For example, 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: _____

_____

☐ **Occupational Therapy** For example, student may have 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: _____

_____

Speech Therapy:

☐ **Articulation** For example, student may have difficulties with: pronouncing words, sounds or sound blends. *Language differences or dialects are not considered speech sound disorders by the American Speech and Hearing Association; your SLP can help respectfully distinguish disorders from differences.*

Describe your concerns: _____

_____

☐ **Language** For example, student may have difficulties with: using words; using words correctly; understanding what is being said; developing age-appropriate conversation. *Language differences or dialects are not considered language disorders by the American Speech and Hearing Association; your SLP can help respectfully distinguish disorders from differences.*

Describe your concerns: _____

_____

☐ **Fluency** For example, student may have difficulties with: stuttering, stammering; refers to sound repetition, part or whole word repetition, or a disruption in the flow of speech.

Describe your concerns: _____

_____

☐ **Psychometry Services** Please list type(s) of testing needed

_____

☐ **Case Management** Services for Writing IEPs (IEP development and maintenance)

_____

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Parent/Guardian: Please complete this page and return to the school.

NEW SCHOOL THERAPY REFERRAL: Page 2

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

To be completed by PARENT/GUARDIAN and/or SCHOOL Case Manager:

STUDENT Name: _____

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

Diagnosis: _____

Concerns: _____

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:** _____ / _____ / _____