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** ☐ Currently Attending ☐ Not Currently Attending
Start Date: _____

Current/Anticipated Schedule: _____

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: _____

_____

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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:** _____ / _____ / _____

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Padre/Tutor: Complete esta página y devuélvala a la escuela.

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/o Administrador de Casos de la ESCUELA

Nombre del estudiante: _____

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

Diagnóstico: _____

Preocupaciones: _____

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:** _____ / _____ / _____