Tallahassee, FL
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Evaluation and Therapy Referral

Child's Name: _____ DOB: ____ /_____ /_____

Parent/Guardian's Name: _____ Phone: _____

Reason for Referral: _____

Address: _____

Child's Doctor: _____ Doctor's Phone: _____

Insurance Provider: _____ Policy #: _____

Is your child currently enrolled in the Early Steps program?
___ No ___ Yes (who is your child's family service coordinator? _____)

Has your child ever received a speech, language or swallowing **evaluation** before?
___ No ___ Yes (when was the most recent evaluation? _____)

Has your child ever received a speech, language or swallowing **therapy** before?
___ No ___ Yes (is he/she currently in therapy? _____ where? _____)

Have you spoken with your child's pediatrician concerning your child's speech, language, feeding, swallowing or developmental skills? ___ No ___ Yes

Sunny Speech Inc. will be faxing a request to obtain a prescription for speech and language services to your child's doctor. Once we have received a prescription, we will contact you to schedule an evaluation to determine your child's eligibility.

I certify that I am aware of this referral and I give Sunny Speech Inc. permission to evaluate and provide services to my child, permission to bill my child's health insurance company, and permission to discuss and disclose my child's healthcare documents with his/her doctor, dentist, case worker, or healthcare professional.

_____ _____
Signature of Parent/Guardian Date

Please fax or email this form to Sunny Speech Inc.