www.SunnyPediatricServices.com
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Office Phone: (850) 909-5521 Fax: (850)391-4178

Feeding Therapy Group Referral

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

Parent/Guardian's Name: _____ Phone: _____

Home Address: _____ Email:_____

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

Insurance Provider: _____ Policy #: _____

Please check all that apply:

My child…

____ has an evaluation from an OT for feeding

____ has an evaluation from an SLP for feeding

____ has received individual feeding therapy

____ is between the ages of 2-6 years

____ has an established condition

____ aspirates or has diagnosed dysphagia

____ is able to sit at a table for at least 15 minutes

____ is able to follow simple commands/directions

Does your child have any food allergies or sensitivities?
___ No ___ Yes (Please specify: _____)

Has your child ever had a swallow study?
___ No ___ Yes (who is your child's family service coordinator? _____)

When and where was your child's last feeding/swallowing **evaluation** by an OT or SLP done?
Name of therapist: _____ Date of evaluation: _____

Has your child ever received feeding/swallowing **therapy** before?
___ No ___ Yes (is he/she currently in therapy? _____ where? _____)

Have you spoken with your child's pediatrician concerning your child's feeding or swallowing 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 the groups have been formed, we will notify you of the date/time of your child's group. Currently feeding groups are private pay only.

I certify that I am aware of this referral and I give Sunny Speech Inc. permission to provide services to my child 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 Pediatric Services