



www.InfantFeedingTherapy.com
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Infant Feeding Referral Form


Baby's name: _____ DOB: ____ / ____ / ____

Parent/Guardian's Name: _____ Phone: _____

Home Address: _____ Email: _____

Baby's Pediatrician: _____ Doctor's Phone: _____

Insurance Provider: _____ Policy #: _____

<u>Type of Services:</u> <input type="checkbox"/> Prenatal Consultation/Class <input type="checkbox"/> Bottle Feeding <input type="checkbox"/> Latch/Positioning <input type="checkbox"/> Feeding Multiples (twins, triplets) <input type="checkbox"/> Feeding/Swallowing Evaluation <input type="checkbox"/> Milk Supply/Pumping <input type="checkbox"/> Maternal Concerns (nipple pain, bleb) <input type="checkbox"/> Colic/Gas/Reflux <input type="checkbox"/> Tongue-tie/Lip-tie <input type="checkbox"/> Other: _____	<u>Private Insurances: Some BCBS, Aetna, or Cigna plans</u> Check eligibility on The Lactation Network:  <u>Medicaid Insurance Plans</u> <input type="checkbox"/> CMS <input type="checkbox"/> Sunshine <input type="checkbox"/> Humana <input type="checkbox"/> I don't have accepted insurance and will pay privately
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Is your infant currently enrolled in the Early Steps program?
 No Yes (who is your child's family service coordinator? _____)

Have you spoken with your infant's pediatrician concerning your baby's feeding, swallowing or developmental skills? No Yes

Sunny Speech Inc. will be faxing a request to obtain a prescription for feeding services to your infant's doctor. Once we have received a prescription, we will contact you to schedule an evaluation to determine your infant'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 infant, permission to bill my infant's health insurance company, and permission to discuss and disclose my infant'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.