www.SunnyBabyServices.com
office@sunnyspeech.com
Office Phone: (850) 909-5521 Fax: (850) 391-4178

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 #: _____

Type of Services:	Private Insurances: Some BCBS, Aetna, or Cigna plans
___ Prenatal Consultation/Class	For lactation clients only, check eligibility on The Lactation Network:
___ Bottle Feeding	
___ Latch/Positioning	
___ Feeding Multiples (twins, triplets)	
___ Feeding/Swallowing Evaluation	
___ Milk Supply/Pumping	Medicaid Insurance Plans
___ Maternal Concerns (nipple pain, bleb)	___ CMS
___ Colic/Gas/Reflux	___ Sunshine
___ Tongue-tie/Lip-tie	___ Humana
___ Other: _____	___ I don't have accepted insurance and will pay privately

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.