2020/21 Helping Hands Therapy Authorization/Referral Form

Requires Parent and Physician Signatures

Therapy desired (check all that apply): ____ PT ____OT ____ST

Student Information

Child's Name:	Date of birth:
Social Security Number:	Medicaid Number:
Guardian's Name and relationship:	Home Address:
Child's Gender:	Phone Number:

School Information

School's Name:	School System/County:
Grade:	Teacher:
School Phone Number:	Special Accommodations or Equipment:
Location for therapy treatments?: ☐At school listed ☐Other, please specify:	

Medical Information

Diagnosis:	Medications:
Primary Physician's Name:	Clinic's Name:
Additional Information: Does child receive outpatient therapy: ☐**Y** ☐ **N** If yes, where:	

Parent or Legal Guardian:

- I give Helping Hands Therapy permission to treat my child.
- I give permission to bill Medicaid for therapy services if applicable and to obtain/share medical information on my child with our physician listed.

Signature _____ **Date**_____

Physician's Approval: I refer the above mentioned child for __PT __OT __ SLP therapy services. This approval is good from the current date through the end of the 2020/21 school year, unless marked otherwise.

Physician's signature _____Date _____

Address: _____

Phone: _____ Fax:_____

Please print physician's name: _____

Contact: **Caseload Coordinator**
● Phone: **334/624-3950** ● Fax: **334/624-3960** ● email: schools@helpinghands-therapy.com