

Helping Hands Therapy

Authorization and Referral Form for Parent(s)

Student Information

Child's Name:	DOB:
Social Security Number:	Medicaid Number:
Gender:	Address:
Parent's Name:	Phone Number:

School Information

School's Name:	Grade:
Teacher:	Special Accommodations or Equipment:

Medical Information

Diagnosis:	Medications:
Primary Physician's Name:	Clinic's Name:
Phone and Fax:	Address:
Additional Information:	

Parent or Legal Guardian: Please initial.

____ I give permission for my child to receive therapy services from Helping Hands Therapy if indicated.

____ I give Helping Hands Therapy the authorization to bill Medicaid for therapy services if applicable,

____ I give Helping Hands Therapy the authorization to obtain any relevant medical information on my child.

Signature _____

Date _____