TWO FISH THERAPY, LLC
(727) 474-4276
admin@twofishtherapy.com

Payment received $45.00 _____

Referral for Therapy Screening

Dear Parents,

You are receiving this packet to gain your permission to have your child participate in an occupational or speech therapy screening. This screen is intended to determine if your child may benefit from therapy services. To begin the screening, the therapist will contact your teacher to discuss and plan which underlying skills to include in the screening process. If areas of concern are identified during the screening a therapist will call you to recommend an evaluation is done and a treatment plan is created to begin to address your child's needs. Once completed, you will receive a screening write up outlining observations and recommendations. Please sign below if you are interested in receiving a screening and a therapist will call you to follow up after the screening has been completed.

Thank you,

Deborah Lund Ms, OTR/L

Students Name:	**Date of birth:**
Grade :	**Therapist:** Debbie Lund Ms, OTR/L
School:	**Teacher:**

Parent Permission and Liability Waiver

My child _____ has permission to fully participate in Two Fish Therapy, LLC screening process. I, as parent/legal guardian, do hereby grant the Two Fish staff the right to authorize emergency medical treatment for my child in the event that I or my designated representative cannot be reached. I agree to hold harmless Two Fish Therapy, LLC and its agents from liability resulting from an accident.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Phone Number: _____ Email: _____Date: _____

Primary concern(s) / reason for referral: Your input is very important to us. Please list any of your areas of concern or reasons for referral below.

Occupational Therapy _____ *Speech Therapy* _____