

Dear Prospective Client:

Thank you for your request for speech-language services in our clinic. Before we can schedule an appointment, we request that the enclosed case history questionnaire and consent-to-participate form be completed and returned to us. We would also appreciate it if you would sign the request for authorization for release of information, mail it to any speech-language pathologist or physician you may have seen within the last 6-12 months, and have them mail us the result of any diagnostic test. If you have a copy of a relevant report, enclose it with the completed forms.

Upon receiving this information, we will send you an acknowledgment letter. Please be aware that our clinic can provide appointments for diagnostic sessions in a relatively quick timeframe, but there is a significant waitlist for our therapy services. We look forward to providing speech-language services to you at the earliest possible date. If you have any questions, please feel free to contact the clinic at (301) 405-4218.

Sincerely,

Elizabeth Coon
Clinic Office Supervisor

EC:

I: spPacket

SPEECH AND HEARING CLINIC
UNIVERSITY OF MARYLAND
COLLEGE PARK, MARYLAND 20742
(301) 405-4218

CHILD CASE HISTORY FORM

Please answer the following questions as best you can and mail the form to the address given at the top of this page. If there are some questions which you cannot answer, leave them blank. Your answers will help us save time in understanding your child's problem.

I. ROUTINE INFORMATION

Name of your child _____ Birthdate _____ Age _____ Gender _____

Name of parents _____

Address _____

Home phone _____ Parent's work phone, Mom's # _____ Dad's # _____

E-mail address _____

Name of person giving information _____

Relationship _____ Phone number if different from above _____

Health Insurance _____

Name of Policy Holder _____ Policy # _____

Race of the child* _____

0 = Not reported

3 = Asian/ Pacific Islander

1 = American Indian/ Alaska Native

4 = Hispanic

2 = Black/ African American

5 = White/ Caucasian

* This information is requested because the University is a public teaching institution and will be used solely for the purpose of describing caseload diversity. Your response will not affect consideration of your child's application.

Why has a speech evaluation been requested?

II. PRESENT SPEECH AND LANGUAGE STATUS

Does your child understand what you say to her/him? _____ If not describe her/his reactions: _____

Does your child have trouble understanding other people's speech? _____ Give examples: _____

Do you know why your child does not understand? _____ Please explain: _____

Does your child respond consistently to sounds in the home (doorbell, phone, etc.)? _____

Explain: _____

Do you suspect a hearing loss? _____ Why? _____

Does your child attempt to talk? _____ Is the child's speech understood by parents? _____

Siblings? _____ strangers? _____

What is your child's reactions when his/her speech is not understood? _____

What does your child do to express himself when his/her speech is not understood by others? _____

Does your child say as much as most children of the same age? _____ Give an example of a sentence your child might say: _____

Does your child pronounce words well? _____ List sounds or words that your child pronounces incorrectly: _____

Select one skill in each column that best describes your child:

- | | |
|---|---|
| <input type="checkbox"/> responds to only loud sounds | <input type="checkbox"/> makes no vocal sounds |
| <input type="checkbox"/> responds only to sounds in the home | <input type="checkbox"/> babbles only |
| <input type="checkbox"/> understands single words | <input type="checkbox"/> says single words |
| <input type="checkbox"/> understands simple sentences | <input type="checkbox"/> speaks in simple sentences |
| <input type="checkbox"/> understands complex directions and sentences | <input type="checkbox"/> uses complex sentences |
| | <input type="checkbox"/> uses only gestures |

Does your child hesitate and/or repeat sounds or words? _____ How often does it happen? _____

When did you first notice this behavior? _____

Describe any struggle behaviors that accompany the hesitations/repetitions: _____

What, if anything, have you done about it? _____

Is your child's voice too high-pitched? _____ too low-pitched? _____ too weak or quiet? _____

Is your child's voice quality unusual? _____ If so, describe: _____

Is your child's speech too fast? _____ too slow? _____

Are there any physical causes for any of the above answers? _____ If yes. Please explain: _____

III. DEVELOPMENTAL HISTORY

A. Birth History

Mother's condition during pregnancy? _____

Full term? _____ If premature, how many weeks gestation? _____

Birth weight? _____ Any evidence of injury at birth? _____

If so, please describe: _____

Indications of weakness or poor health at birth?

Explain: _____

Any difficulty in initiating breathing? _____

B. Growth

During infancy, did your child demonstrate any feeding or swallowing problems? Please describe: _____

Has your child increased in height and weight normally? _____ If not, please describe: _____

C. Motor

Age of sitting up _____ Age of crawling _____ Age of walking _____

Does your child seem to have normal coordination for his/her age? _____ If not, please describe: _____

Which hand does your child use? _____

D. Speech Development

Did your child babble and coo during the first ten months? _____ At what age did your child use single words meaningfully? _____ Age for short phrases/sentences? _____

E. General Development

Does your child have opportunities to play with other children? _____ What ages? _____ How many? _____

Does your child like to play with other children or would your child prefer to play alone? _____

At what age did your child start feeding himself/herself? _____

Dressing himself/herself? _____ Become toilet-trained? _____

Does your child present any special behavior problems? _____ If so, please describe: _____

Check all of the following which describe your child:

- | | | |
|------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Unresponsive | <input type="checkbox"/> Temper Outbursts |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Quiet | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Tense |
| <input type="checkbox"/> Sensitive | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Talkative |

IV. MEDICAL HISTORY

A. List diseases/conditions and their effects and severity:

Disease/Condition	Age	Severity and Effects
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B. List significant injuries, ages and effects:

Injury	Age	Severity and Effects
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C. List operations and ages for each operation:

Operation	Age	Severity and Effects
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D. Name of child's current pediatrician _____

E. Address _____

F. Please list any conditions for which child is currently taking medication

Name and dosage of each medication _____

Does your child have any allergies or dietary restrictions? _____

V. SCHOOL HISTORY

A. Please complete all of the following that apply to your child:

Attended	Name and Location	Age Entered	Dates
Nursery School:	_____		
Elementary School:	_____		
Junior High:	_____		
Senior High:	_____		

B. Status

List subjects that are especially difficult for your child _____

Describe any serious behavior problems at school _____

Has your child ever repeated a grade? _____ Which one and why? _____

Has your child's school attendance been regular? _____

Describe your child's participation in after-school activities? _____

VI. SPEECH-LANGUAGE HISTORY

A. Describe any special work in speech and/or language in school _____

Dates _____ Group or individual sessions _____ Frequency _____

Name of therapist and school _____

B. Has your child received any speech/language services at any other clinic or agency? _____

Please list the names of other clinics or agencies where your child has been evaluated or treated for speech-language or hearing difficulties. Please attach copies of any reports to this form.

	Name	Location	Dates	Evaluated	Treatment
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

C. Describe any help given to your child by his family, friends, physicians, which has not been reported previously, in attempts to help your child correct his present speaking difficulties.

VII. FAMILY and SOCIAL HISTORY

A. Family

Father's name _____ Age _____

Place of birth _____ Occupation _____

Education completed: _____ 8th grade _____ High school _____ College _____ Other _____

Mother's name _____ Age _____

Place of birth _____ Occupation _____

Education completed: _____ 8th grade _____ High school _____ College _____ Other _____

Names and age of brothers and sisters _____

Others in household _____

Describe any family history of speech/language or hearing difficulties (e.g. learning disabilities, stuttering, articulation impairment, deafness, etc.)

List any languages other than English that are spoken in your child's home or everyday environment _____

Please attach a recent photograph of your child. Since this photograph will not be returned to you, you need not send an expensive one. A snapshot will serve the purpose.



University of Maryland Speech and Hearing Clinic
College Park, Maryland 20742 (301) 405-4218

Consent Form

The Department of Hearing and Speech Sciences at the University of Maryland has three purposes: to train speech-language pathologists and audiologists, to render services to clients, and to conduct research in hearing, speech, and language. In order to meet these purposes, any of the following diagnostic, therapeutic, teaching, and/or research procedures may be used by authorized personnel within the department: direct observation, audio taping, video taping, photography, and review of client records. For research purposes, clients may be asked to participate in research projects conducted by authorized personnel. Client participation in any **research** project is strictly voluntary, and refusal to participate will in no way affect clinical services rendered to the client.

I consent to the participation of _____ in the clinical services of
Name of Client
the Department of Hearing and Speech Sciences at the University of Maryland.

In addition, I give permission for recordings (audio, video, photographic, transcripts, etc.) of clinical services to be permanently stored for review by authorized students and faculty of the Dept. of Hearing and Speech Sciences for the purposes of instruction/training for students and professionals in the discipline.

I grant this consent with the understanding that any use of privileged information, other than to meet the department's stated purposes, will not be undertaken without further written consent.

Signature: _____ Date: _____

Print Name: _____

Address: _____

Relationship to Patient: _____

The University of Maryland complies with all applicable federal, state, and local laws, including, but not limited to, the Americans with Disabilities Act of 1990, the Civil rights Act of 1964, the Equal Pay Act, the Age Discrimination in Employment Act, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (to the Higher Education Act of 1965), the Rehabilitation Act of 1973, the Vietnam-Era Veterans Readjustment Assistance Act 1974, and all amendments to the foregoing.



**Authorization for Release of Records
from the University of Maryland**

Patient Name: _____ DOB: _____

I hereby consent to the release of any and all hearing, language, and speech records for the individual named above to:

Name / Agency: _____

Address: _____

Name / Agency: _____

Address: _____

This information pertains to assessment and treatment by the Speech and Hearing Clinic, University of Maryland, College Park.

Signature: _____ Date: _____

Name: _____

Relationship To Patient _____

Witness: _____

FOR CLINIC USE ONLY – REPORTS TO BE MAILED

Report(s) Reports(s) Date Supv. Sig. Sent Sec

University of Maryland Speech and Hearing Clinic
College Park, Maryland 20742 (301) 405-4218



**Authorization for Release of Information
from Agency or Physician
to the University of Maryland**

Patient Name: _____ DOB: _____

Agency or Physician: _____

Address of Agency or Physician: _____

The above named person has requested the services of the University of Maryland Speech and Hearing Clinic. We understand that this individual was seen at your facility. Kindly forward any hearing, language, speech, medical, psychological, educational, or social information regarding the above named individual.

Please send your reply to the attention of Beth Coon, Office Manager, University of Maryland Speech and Hearing Clinic, College Park, MD 20742.

Thank you for your prompt cooperation.

Date: _____

This will certify that you have my permission to release information concerning the individual named above to the University of Maryland Speech and Hearing Clinic.

Signature: _____

Name: _____

Address: _____

Relationship
To Patient: _____

POLICY STATEMENT

The purposes of the University of Maryland Speech and Hearing Clinic are:

1. To provide a training facility for those students seeking to become certified speech pathologists and audiologists.
2. To provide an environment for research.
3. To provide speech and hearing services to the public.

Because the clinic is a training facility for students, services are provided to the public at a reduced cost. All students conducting clinical sessions are supervised by Speech-Language Pathologist and Audiologists licensed by the State of Maryland and certified by the American Speech and Hearing Association. The clinic operates by appointment only, and follows the academic calendar of the University of Maryland. Services of this clinic may occasionally be cancelled for professional meetings.

Since we have a commitment to provide varied experiences for students, acceptance into the clinical program is of a selective nature and cannot be guaranteed from semester to semester. In addition, we cannot assure you of immediate placement in our program following the initial examination. We make every effort to provide the needed rehabilitative services, but it is sometimes necessary for us to place prospective clients on a waiting list. If accepted into the program, clients are expected to maintain regular and punctual attendance. If frequent absence or tardiness occurs, we reserve the right to dismiss the client from our program. If a session is missed due to clinic emergencies, the session will be make up another time or the fee for that sessions refunded. Clients are responsible for payment of sessions they cancel.

We trust that the above policy statements will contribute toward a smooth running, pleasant experience for all those who participate in the program at the University of Maryland Speech and Hearing Clinic.

BILLING POLICY

Diagnostic evaluations are scheduled for three-hour time slots and billed at a flat rate (call for Fee Schedule). Full payment is due at the time service is rendered. Cancellations must be made more than 24 hours in advance of the scheduled testing date. Clients who cancel diagnostic appointments with less than 24 hours notice will be billed a \$75.00 fee.

Speech therapy fees are billed on a semester basis and are calculated based on the number of sessions per week multiplied by the weeks of service. Full payment is due on or before the first day of therapy unless specific alternate arrangements are made with the clinic office manager or clinic director.

Cancellations: Clients are responsible for paying for every scheduled session. Any sessions cancelled by clients (whether for vacation or illness) are not subtracted from the semester bill. Attempts will be made to arrange make-up sessions at times mutually convenient to both the client and clinician. However, if a make-up sessions cannot be scheduled, the client will be billed for the cancelled session.

If your clinician cancels a session for any reason or the University of Maryland in College Park closed for severe weather conditions, it is the clinician's responsibility to provide a make-up session. If a mutually convenient date is not available, then the clinic will cancel the charge for that therapy session.

Insurance: We encourage clients to investigate the possibility of insurance coverage for speech-language services. However, please note that clients are responsible for paying their bill in full on the first day of therapy and then requesting reimbursement from their insurance provider. The clinic cannot validate claim forms before semester bills have been settled. Clients should request that their insurance company reimburse them directly. If the insurance company sends a direct payment to the clinic, we will return it to the insurance company to be re-issued, to refund the client.