

**University of Washington
Speech and Hearing Clinic**
4131 – 15th Avenue Northeast
Seattle, Washington 98105
Phone: 206-543-5440 – V/TTY
Fax: 206-616-1185
<http://depts.washington.edu/sphsc>

<i>Clinic Use Only</i>
Date application received: _____
File # Assigned: _____
Entered into DB: _____

Today's Date:

APPLICATION FOR SPEECH AND LANGUAGE SERVICES - CHILD

I. Identifying Information

<i>Patient</i>		
Child's name:	Birthdate:	Sex:
Parents' names:		
Parents' address:	City:	
State:	Zip:	Parent's phone: ()
Work Phone: ()	Whose phone number is it?	
E-mail:		
What is the best way to contact you during the day: <input type="checkbox"/> home phone <input type="checkbox"/> work phone <input type="checkbox"/> e-mail		

<i>Person completing this form</i>	
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:	
Who referred you to us? Name:	Profession:

<i>(Leave the next four lines blank if you are the parent.)</i>	
Your name:	Relationship to child:
Your phone: ()	Work phone: ()
E-mail:	
What is the best way to contact you during the day: <input type="checkbox"/> home phone <input type="checkbox"/> work phone <input type="checkbox"/> e-mail	

<i>Services Desired (check all that apply)</i>
<input type="checkbox"/> Evaluation <input type="checkbox"/> Treatment <input type="checkbox"/> Other _____
<small><i>If you only want to be put on the treatment waitlist, you must provide a complete report of an evaluation that was done by another agency (e.g., private or school speech-language pathologist, etc.) from within the last 12 months. If you are being seen by another speech-language pathologist please provide other information such as progress notes, Individual Education Programs, etc. Please note that while we do accept reports from outside agencies, clients who are seen here for an evaluation get priority for receiving treatment through this clinic over clients who are only submitting outside documents.</i></small>

II. Chief Concerns

Please respond to any of the items below that will give us more information about your child's communication.

Please indicate the reason(s) why you are coming to this clinic and your expectations:

Do you or other people have concerns about your child understanding language (e.g., answering questions, following directions, etc.)? If yes, please explain.

Do you or other people have concerns about how your child puts together sentences (e.g., sentences are shorter than expected, word order is incorrect, little parts of speech or word endings are missing such as "is/are", past "-ed", etc.). If yes, please explain.

How does your child usually try to express him or herself?

- r Actions (like crying, pulling adult's hand)
- r Sounds (like babbling)
- r Gestures (like pointing)
- r 1-2 word sentences
- r 3-4 word sentences
- r Complete sentences
- r Other (like pictures or communication boards): _____

Does your child have difficulty pronouncing sounds? Please explain.

Can you understand what your child is saying all or most of the time? If no, please explain.

Can others understand what your child is saying all or most of the time? If no, please explain.

II. Chief Concerns

Does your child ever express frustration when communicating? Please list specific concerns; use a separate page if necessary.

Does your child "get stuck," repeat or stutter on words or sounds when he or she is talking? If yes, please explain.

Do you have any concerns about your child's voice? If so, please explain.

Are there any other concerns that you have about your child's speech, language or learning?

III. School History

Is your child currently in any kind of school (e.g., preschool, elementary, etc.)? Yes No

Name of School _____ Grade _____
Teacher _____
Address _____
Phone Number _____
Type of Classroom* _____

* Montessori, special education, regular education, etc.

Did your child ever repeat a grade? If yes, please explain.

III. School History

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Previous testing and/or services at school:

Under each grade, please put a check in the corresponding boxes below if **testing** or **services** were provided for your child in the areas listed.

☐ Please check here if no testing or services have been provided in any grade.

Resource Room	Tested Services	PreK	Kg	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	

School Psychologist	Tested Services	PreK	Kg	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	

Speech Language	Tested Services	PreK	Kg	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	

Reading (LAP, Title 1)	Tested Services	PreK	Kg	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	

OT/PT	Tested Services	PreK	Kg	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	

ESL (English as a Second Language)	Tested Services	PreK	Kg	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	

Other	Tested Services	PreK	Kg	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	

If "other", please explain:

Current Individualized Education Program (IEP):

If your child currently has an IEP, please provide the most recent one.

☐ Please check here if your child does not have an IEP.

IV. Services Received OUTSIDE of School

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Previous TESTING. Please provide any available reports from these sources.		p Check here if none.
<i>please use a separate page if necessary</i>		
Speech/language, cognition, reading or other? (circle one)	When?	Where?
By whom?	Results:	
Speech/language, cognition, reading or other? (circle one)	When?	Where?
By whom?	Results:	
Speech/language, cognition, reading or other? (circle one)	When?	Where?
By whom?	Results:	

Previous Diagnoses:

Has your child been given any diagnosis or are there any labels used to help describe your child's problem/s?

r No r Yes

- If Yes, please describe: _____

- Who gave the diagnosis: _____

IV. Services Received OUTSIDE of School		
Previous THERAPY SERVICES . Please provide any available reports from these sources.		p Check here if none.
<i>(please use a separate page if necessary)</i>		
Speech/language, reading or other: _____? <small>(circle one)</small>	When?	Where?
By whom?	Results:	
Speech/language, reading or other: _____? <small>(circle one)</small>	When?	Where?
By whom?	Results:	
Speech/language, reading or other: _____? <small>(circle one)</small>	When?	Where?
By whom?	Results:	

V. Birth/Health History
Please explain any difficulties before, during or after the birth of your child.
Has your child ever been hospitalized? <input type="checkbox"/> yes <input type="checkbox"/> no Date: Reason:
Any other medical concerns? <input type="checkbox"/> yes <input type="checkbox"/> no Please specify:

V. Birth/Health History

Is your child taking any medicines regularly? yes no Please specify:

Hearing

Is hearing normal? yes no

Date of most recent hearing test:

Hearing aids used? yes no

Frequent ear infections? yes no

Comments:

Vision

Is sight normal? yes no

Date of most recent eye exam:

Does child wear glasses? yes no

Comments:

VI. Speech and Language Development

At what age (approximately) did your child do the following:

Babble (combine consonants and vowels in strings like “bababa” or “gagaga”) _____

Say first word(s) _____

Jabber in “nonsense” sentences that sound like adult language _____

Begin to put words together (i.e. “Daddy go” “Mommy play toy”) _____

VII. Motor Development

At what age (approximately) did your child do the following?

Hold head up _____

Sit up unassisted _____

Take first steps _____

Walk without help _____

VIII. Other Developmental Concerns

Please indicate if you have had in the past or currently have any concerns about the following areas of development.

Past	Currently	
<input type="checkbox"/>	<input type="checkbox"/>	Motor (e.g., crawling, walking, running, clumsiness)
<input type="checkbox"/>	<input type="checkbox"/>	Social (e.g., playing or interacting with adults, siblings or peers)
<input type="checkbox"/>	<input type="checkbox"/>	Self-help (e.g., dressing, toileting)
<input type="checkbox"/>	<input type="checkbox"/>	Feeding (e.g., drooling, choking, sensitivity to textures)
<input type="checkbox"/>	<input type="checkbox"/>	Play (e.g., using toys appropriately)

Please explain any concerns:

IX. Home/Social Environment

Parent Information:

Mother's name:	Father's name:
Birthdate:	Birthdate:
Occupation:	Occupation:
Last grade completed in school:	Last grade completed in school:
Divorced/separated?:	When?

Family

Is there any family history of speech, language and/or learning problems? If so, please describe.
Family attitude toward child's current difficulty?
Languages spoken in the home:
Language used most often:
Is English a second language? <input type="checkbox"/> yes <input type="checkbox"/> no

IX. Home/Social Environment

Siblings

Brothers:	Ages:	Any problems?
Sisters:	Ages:	Any problems?

X. Insurance Information

The Speech and Hearing Clinic does not bill insurance companies. When services are paid in full by cash or check, the clinic will issue an Itemized Insurance Statement you can submit to your Insurance Carrier for reimbursement. We DO accept Medical Coupons* from the State of Washington for payment for DSHS covered services.

Do you have Medical Coupons?* (DSHS) YES: _____ NO: _____
 (*We must have a current copy on file of a DSHS coupon per month for services rendered.)

Please return these forms in the envelope provided.

**Speech and Hearing Clinic
University of Washington
4131 – 15TH Avenue NE
Seattle, WA 98105**

Instructions: Please read this consent form carefully. If you are comfortable with the contents therein, please sign this form and return it with your application materials. If you have any questions or concerns about this form, please return the application without it. Then bring this form (unsigned) to the first appointment.

Consent Form

This Service Agreement and Consent (“Agreement”) is between you and the University of Washington Speech and Hearing Clinic (“the Clinic”). This Agreement concerns: (1) your financial obligations; and (2) your consent to have recordings made of the person receiving services (the “client”) and/or the person authorizing services (the “authorizing individual”).

1. Your Financial Obligations

You are responsible for the fees for service stated on the attached face sheet. The Clinic does not directly bill insurance companies or Medicare/Medicaid. You are responsible for payment of all fees to the Clinic regardless of any such coverage. The Clinic will furnish you an itemization of services received and paid for in cases where insurance companies will reimburse for services.

The exception to the above is if you have valid medical coupons issued by the Department of Social and Health Services (DSHS). In that case, you must show a current medical coupon to verify eligibility and your clinic fees will then be waived.

Fees are subject to change without notice

2. Your Consent for Services and Recording

The services offered to individuals seen in the Clinic and its affiliated laboratories are part of the University’s education program. University of Washington faculty, staff, and students receive educational benefits from observing diagnostic, treatment, and other services offered in the University of Washington facilities.

2a. Minimum Consent:

By accepting services from the Clinic and its affiliated laboratories, you consent to observation by University of Washington faculty, staff, and students, either live, via recording or via closed circuit television when you (or the client) receive services.

2b. Additional Consent:

In addition, the University of Washington may make audio and/or video recordings of you (or the client) during such service periods to be used for the University’s educational, research or technology transfer purposes provided the name of the client or other personal identification information is not revealed. The University may use, distribute, reproduce, and display these recordings, in whole or in part and in any media now known or later developed (including the World Wide Web, television and/or CD-Rom) or may permit others to do so. Such uses may include, but are not limited to, the following:

- Viewing/listening by registered students or participants in activities conducted, sponsored or licensed by University of Washington faculty or staff.
- Viewing/listening by the general public at activities or through media sponsored or licensed by the University of Washington or its faculty or staff. (e.g. Internet/World Wide Web, University of Washington TV)
- Viewing/listening by the general public through licensed commercial enterprises for

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educational or research purposes, for example a CD-Rom enclosed in a textbook.
Again, if you have any questions or concerns about these uses of recordings, please bring this form (unsigned) to the first appointment to discuss alternatives.

Name of client

Date

Signature of Authorizing Individual

Relationship of Authorizing Individual to the Client:

- Self
- Parent
- Legal guardian
- Other. Please explain relationship: _____

Printed Name of Authorizing Individual: _____

Address of Authorizing Individual: _____

Phone Number of Authorizing Individual: _____

For Office Use Only:

Date Received: _____

Received by: _____

UNIVERSITY OF WASHINGTON Speech & Language: Mutual Exchange of Information
SPEECH AND HEARING CLINIC
4131 15TH AVENUE N.E.
Seattle, WA 98105
Phone: (206) -543-5440
Fax: (206)- 616-1185
<http://depts.washington.edu/sphsc>

I hereby give permission for the mutual exchange of information regarding:

(Clients First Name Middle Name Last Name) (Date of Birth)

between the University of Washington Speech and Hearing Clinic and the following agency, professional or individual:

(Name)

(Address)

(City) (State) (Zip)

Attention: _____

This release is good for ninety (90) days from the date below and must be renewed for use beyond that time. I understand that I will be notified of any other requests for information that are received by this office, in order to give my permission to release this information of the above named individual. I understand this information will be shared for professional use only and that confidentiality will be maintained. I may revoke this release in writing at any time.

(Signature of Client or Guardian) (Date)

(Signature of Client or Guardian) (Date)

(Signature of Client or Guardian) (Date)

(Signature of Client or Guardian) (Date)

C: revised 8/01