

Parent or Legal Guardian		Street Address			
City, State Zipcode		Telephone		Email Address	
Primary Insurance		Name of Primary Card Holder		Primary Card Holder's Date of Birth	
Primary Cardholder's Place of Employment		Employer's Address			
Subscriber ID No.		Group No.		Card No.	
Payer ID No.					
Co-pay Amount	Effective Date	Customer Service Tel.	Claims Address		
Secondary Insurance		Name of Cardholder		Date of Birth	
Card No.		Payer ID No.		Claims Address	
**** MAKE A COPY OF YOUR INSURANCE CARD AND ATTACH TO THIS FORM ****					
Client's Full Name		Date of Birth	Age	Sex	Social Security Number
Serious Illnesses ? ___ YES ___ NO	Hospitalizations / Surgeries ? ___ YES ___ NO	If YES to either, please explain			
Birth / Medical History	Length of Gestation	Pregnancy Complications (if any)		Delivery Complications (if any)	
Has the child been diagnosed with any of the following (check all that apply)					
___ Head Trauma ___ Attention Deficit Disorder ___ Learning Disability ___ Autism ___ Developmentally Delayed ___ Cerebral Palsy ___ Behavior Disorder ___ Cleft Palate ___ Short Frenum "tongue tied" ___ Vocal Nodules ___ Vision Problems ___ Hearing Problems ___ Stroke ___ Paralysis of face or other ___ Seizures ___ Premature Birth ___ Down's Syndrome ___ Tourette's Syndrome ___ Dyslexia ___ Vision Problems (Glasses/Contacts) ___ Allergies					
If you checked any of the above, please provide more detail					
Has your child ever seen a Neurologist ? ___ YES ___ NO		Name of Neurologist		Neurologist's Telephone No.	
Child's Primary Care Physician (PCP)		PCP's Address		PCP's Telephone No.	Date of Last Physical Exam
Did PCP provide a referral ? ___ YES ___ NO	Has child had a hearing test ? ___ YES ___ NO	Date of Exam		Please provide a copy of results, if available.	

General results of Hearing Test

SPEECH - LANGUAGE DELAY REFERRALS

Check all that apply (early stages of language development): *Indicates what the child can express verbally

Uses gestures to communicate Uses vocalizations Is difficult to understand ≤ 50 word vocabulary ≤200 word vocab. ≤500 word vocab. I understand most of what he says Is nonverbal Follows 1 direction requests Follows more than 1 direction requests Usually uses 1 word or 1 word approximations to communicate Puts two word sentences together other than "Thank You", "Bye Bye", "No No" Uses the same vocalization in a variety of situations

Check all that apply (later stages of language development)

Difficulty with basic concepts (on, under, above, big, little) Difficulty following multi-step directions Has a limited vocabulary Is learning to read, but has some difficulty Has a lot of problems reading Knows letters and the sounds they make Problems with grammar usage (past tense, pronoun usage, etc.) Initiates appropriate conversations with peers

If being referred for stuttering, check all that apply

Blocks on words Repeats whole words Repeats individual phonemes Repeats partial words Child does not notice problem Worse under stress Others notice Causes anxiety/depression Problem is mild Problem is moderate Problem is severe Stuttering less than 6 mo. Stuttering more than 6 mo. Getting worse Body movements are associated with stuttering

Answer the following if the person is being referred for an articulation or phonological process disorder (there is no right or wrong answer)

My child has a lot of errors and is hard to understand YES NO

My child has a few errors YES NO

Please describe the errors you hear:

Does your child drool? YES NO

OCCUPATIONAL THERAPY REFERRALS

At what age did your child :	Hold his or her head up independently?	Sit independently?	Crawl?	Walk?
Does Your Child Fall Frequently ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does he / she keep up with his / her peers ? <input type="checkbox"/> YES <input type="checkbox"/> NO	If not, what are he/she not able to do ?		

What have you noticed about your child's skills that most concern you

Does your child regularly exhibit any of the following behaviors? Check all that apply.

Has a short attention span Seems overly energetic in play Lacks self control Seems impulsive Difficulty showing affection Overreacts when faced with problems Difficulty following directions Uncomfortable meeting new people Has excessive fears Requires a lot of parental attention Poor eye contact Poor safety awareness Poor interpersonal boundaries Difficulty transitioning

If you checked any of the above, please provide more detail

SCHOOL / THERAPY HISTORY

Does the child attend:

High School Middle School Elementary School Preschool Nursery School Play Group
 Day Care

Days Attending

Mon Tues
Wed
 Thur Fri
Sat

Name of Program: _____

Contact Telephone No.

May TCS Contact Program Regarding
Child's Development ?

YES NO

Describe Child's Adjustment

Has child had a speech-language
evaluation in the past ?

YES NO

If YES, date

What Were the Results ?

PASS FAIL

Describe Results

Has child had a speech therapy
in the past ?

YES NO

Describe the therapy he/she was receiving and the results. What were some things you liked and disliked about the therapy?

**** PLEASE PROVIDE A COPY OF ANY PAST EVALUATIONS AND THERAPY REPORTS WHEN YOU SUBMIT THIS FORM ****

Please provide any additional information you believe would be helpful in determining the best course of action for your child.