

<b>Parent or Legal Guardian</b>		Street Address			
City, State Zipcode		Telephone		Email Address	
<b>Primary Insurance</b>		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		
<b>Secondary Insurance</b>		Name of Cardholder			Date of Birth
Card No.	Payer ID No.	Claims Address			
<b>*** MAKE A COPY OF YOUR INSURANCE CARD AND ATTACH TO THIS FORM ***</b>					
<b>Client's Full Name</b>		Date of Birth	Age	Sex	Social Security Number
Serious Illnesses ?	Hospitalizations / Surgeries ?	If YES to either, please explain			
<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO				
<b>Birth / Medical History</b>	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)					
<input type="radio"/> Head Trauma <input type="radio"/> Attention Deficit Disorder <input type="radio"/> Learning Disability <input type="radio"/> Autism <input type="radio"/> Developmentally Delayed <input type="radio"/> Cerebral Palsy <input type="radio"/> Behavior Disorder <input type="radio"/> Cleft Palate <input type="radio"/> Short Frenum "tongue tied" <input type="radio"/> Vocal Nodules <input type="radio"/> Vision Problems <input type="radio"/> Hearing Problems <input type="radio"/> Stroke <input type="radio"/> Paralysis of face or other <input type="radio"/> Seizures <input type="radio"/> Premature Birth <input type="radio"/> Down's Syndrome <input type="radio"/> Tourette's Syndrome <input type="radio"/> Dyslexia <input type="radio"/> Vision Problems (Glasses/Contacts ) <input type="radio"/> Allergies					
If you checked any of the above, please provide more detail					
Has your child ever seen a Neurologist ?		Name of Neurologist		Neurologist's Telephone No.	
<input type="radio"/> YES <input type="radio"/> NO					
Child's Primary Care Physician (PCP)	PCP's Address		PCP's Telephone No.		Date of Last Physical Exam
Did PCP provide a referral ?	Has child had a hearing test ?	Date of Exam		<b>Please provide a copy of results, if available.</b>	
<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO				
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:

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Does your child drool?  YES  NO

### OCCUPATIONAL THERAPY REFERRALS

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

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### 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.