The Treatment and Learning Centers
TLC
a family of services where caring comes first

2092 Gaither Road, Suite 100
Rockville, Maryland 20850
301.424.5200
Fax 301.424.8063
TTY 301.424.5203
www.ttlc.org

# FEEDING EVALUATION CASE HISTORY FORM

The following information will be read by the therapist who is performing the initial work with your child. It will help us to perform the best tests for your child. Your opinion and information is very helpful. **We will ask you to complete this information at the first visit if you are not able to complete it prior to the session**.

## Child Information

Date

| | | | |
|---|---|---|---|
| Name / Gender | Name | | Gender ☐ M ☐ F |
| Date of Birth / Age / School | Date of Birth | Age | Grade / School |
| Weight/Height | Weight | Height | |
| Home Address | Street<br>City | State | Apartment<br>Zip Code |
| Emergency Contact | Name | | Phone |

## Parent / Guardian Information

| | | | |
|---|---|---|---|
| Parent / Guardian One | Name | | Gender ☐ M ☐ F |
| Phone Number | Home | Work | Cell |
| Employment | Employer Name | Occupation | |
| Parent / Guardian Two | Name | | Gender ☐ M ☐ F |
| Phone Number | Home | Work | Cell |
| Employment | Employer Name | Occupation | |
| E-mail Address | Parent / Guardian One | Parent / Guardian Two | |

## Who referred you to TLC?

| | |
|---|---|
| Name | |
| Relationship to Child | |
| Reason for Referral | |
| Previous services by any TLC department? | |

## Other Primary Caregivers

| *Caregiver (other than parent / guardian)* | | |
|---|---|---|
| Name | Address | Phone |

## Please List all People Residing in your Home

| Name | Relationship | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Significant Family Medical History

[e.g., Speech-Language, Hearing, Sensory/Motor or Learning Disability; impaired attention; anxiety / depression; other disease or condition]

| Name | Relationship | Diagnosis |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**REASON FOR VISIT:**

1. Describe primary concern(s) for your child:

_______________________________________________________________________________

_______________________________________________________________________

2. What do you hope to obtain from this evaluation?

_______________________________________________________________________________

_______________________________________________________________________

**3. Please list any other concerns that you have:**

_______________________________________________________________________________

_______________________________________________________________________

## Birth and Developmental History

| Birth and Infancy | | | | |
|---|---|---|---|---|
| *Pregnancy* | YES | NO | N/A | Additional Information |
| Was mother's health during pregnancy good to excellent? | | | | |
| Were medications taken during pregnancy? | | | | What / when: |
| Was baby born at term (due date) or within two weeks before / after the due date? | | | | |
| What was baby's birth weight? | | | | |
| Was your child adopted? | | | | Country of Origin: |
| If adopted, what was child's age at adoption? | | | | |
| If adopted, is there any known history that could be related to the current problem? | | | | |
| *Labor and Delivery* | | | | |
| Were labor and delivery normal? | | | | |

| | | | | |
|---|---|---|---|---|
| Was labor induced? | | | | |
| Was birth by Caesarian Section? | | | | |
| Was there evidence of injury or poor health at birth? | | | | |
| Was your child on mechanical ventilation after birth? | | | | |
| What were baby's APGAR scores? | | | | |
| Other: | | | | |
| | | | | |
| | | | | |
| | | | | |
| *Infancy* | | | | |
| Were there any feeding problems? | | | | |
| Does your child have a history of GERD? | | | | |
| Did your child transition from bottle to table foods easily? | | | | |
| Did baby exhibit average activity level? | | | | |
| During the first several months of life, was baby's health good? | | | | |
| Tonsillectomy? | | | | |
| Adenoidectomy? | | | | |
| Other: | | | | |
| | | | | |
| | | | | |

## General Development

| *Developmental Milestones* | | N/A | Additional Information |
|---|---|---|---|
| When was child able to sit unassisted? | Age: | | |
| When did crawling emerge? | Age: | | |
| When did walking emerge? | Age: | | |
| When did child begin to babble? | Age: | | |
| When did child produce first words? | Age: | | |
| When did child begin combining words? | Age: | | |

| *Communication* | YES | NO | N/A | Additional Information |
|---|---|---|---|---|
| Did speech and language development seem to progress normally, and then stop or regress? | | | | |
| Does child seem to understand what is said? | | | | |
| Does child follow spoken directions? | | | | ❑ 1-step ❑ 2-step ❑ 3+ steps |
| Does child talk? | | | | |
| Does child produce vocalizations that sound like the language of the home, but are unintelligible (e.g., jargon-like)? | | | | |
| Which of the following does child use most often? | | | | ❑ Sounds ❑ Syllables ❑ Gestures<br>❑ Sounds + gestures ❑ Single words<br>❑ Series of single words (pauses between words)<br>❑ Single words + short phrases<br>❑ Complete / grammatically <u>incorrect</u> sentences<br>❑ Complete / grammatically CORRECT sentences<br>❑ Retells stories / experiences others understand |
| Does child often hesitate when speaking and/ or repeat sounds / words / phrases? | | | | |
| Child's speech / pronunciation is | | | | ❑ Understood by everyone |

| | | | | ❑ Understood by family / caregivers<br>❑ Poorly understood<br>❑ Unintelligible ❑ Absent |
|---|---|---|---|---|
| Child's speech rate is | | | | ❑ Too Fast ❑ Too Slow ❑ Average |
| Child's volume is | | | | ❑ Too Soft ❑ Too Loud ❑ Average |
| Child's voice quality is | | | | ❑ Hoarse ❑ Nasal ❑ Average<br>❑ "Stuffed" – Like during a cold |
| Other: | | | | |
| ***Hearing*** | **YES** | **NO** | **N/A** | **Additional Information** |
| Does child have a history of hearing loss? | | | | |
| Does child wear a hearing aid? | | | | |
| Does child appear to have difficulty hearing? | | | | |
| Is child consistent in response to sounds and voices? | | | | HA Type: |
| Please provide information regarding child's most recent hearing test. | Date: | | | Results: |

| Medical History | YES | NO | N/A | Additional Information |
|---|---|---|---|---|
| Please list all diagnoses: | | | | |
| Has child ever had a fever of 104º or more? | | | | |
| Is child currently under treatment for any medical condition? | | | | |
| Is development of teeth normal? | | | | |
| Does child sleep well? | | | | |
| Does child have a good appetite? | | | | |
| Is child on a special diet? | | | | |
| | | | | |
| ***Medications*** | | | | |
| **Please complete this section if child takes prescription or over-the-counter medication regularly.** | **Name** | **Dose** | **How Often** | **Reason Taken** |
| Medication: | | | | |
| Medication: | | | | |
| Medication: | | | | |
| Medication: | | | | |
| Medication: | | | | |
| ***Diseases or Conditions*** | | | | |
| **Please provide information regarding history of diseases.** | **Age** | **Describe Treatment and / or Complications** | | |
| Allergies (i.e., food, insect bites, latex, pollen, medication, etc.) | | | | |
| Chicken Pox | | | | |
| Chronic Colds | | | | |
| Ear Infections | | | | |
| Lead Poisoning | | | | |
| Measles | | | | |
| Mumps | | | | |
| Spasms, convulsions, or seizures | | | | |
| Tonsillitis | | | | |
| Other: | | | | |
| | | | | |

| *Injuries and / or Surgeries* | | |
|---|---|---|
| Please provide information regarding any injury, surgery, or hospitalization. | Age | Describe Treatment and / or Complications |
| | | |
| | | |
| | | |
| | | |

| *Previous Evaluations* | YES | NO | Dates of Svc. | Agency/Person |
|---|---|---|---|---|
| Educational / Psychological Testing | | | | |
| Hearing / Audiology Evaluation | | | | |
| Occupational Therapy Evaluation | | | | |
| Physical Therapy Evaluation | | | | |
| Speech Language Evaluation | | | | |
| Feeding Evaluation | | | | |

| *Current and/or Previous Therapy (List All)* | YES | NO | Dates of Svc. | Agency/Person |
|---|---|---|---|---|
| Counseling | | | | |
| | | | | |
| | | | | |
| Occupational Therapy | | | | |
| | | | | |
| | | | | |
| Physical Therapy | | | | |
| | | | | |
| | | | | |
| Speech Language Therapy | | | | |
| | | | | |
| | | | | |
| Feeding Therapy | | | | |
| | | | | |
| | | | | |
| Other: | | | | |
| | | | | |

*Other Information related to Medical and / or Developmental History*

Other information you would like us to know about your child's medical and / or developmental history:

*If child exhibits or has exhibited the following behaviors, please indicate age of occurrence and describe strategies used to address the behaviors.*

| Behavior | Age (from – to) | Strategies Used to Address Behavior |
|---|---|---|
| Bedwetting | | |
| Depression | | |

| | | |
|---|---|---|
| Difficulty separating from parents | | |
| Difficulty sitting still | | |
| Frequent headaches / stomach aches | | |
| Inability to stay with one activity until completion | | |
| Negative self-esteem | | |
| Nervousness / anxiety | | |
| Noncompliant / defiant | | |

| **Please answer the following questions regarding your child's behavior.** | |
|---|---|
| What types of activities or toys does your child prefer? | Please describe: |
| ***Other Information related to Social and Emotional History*** | |
| Other information you would like us to know about your child's social and emotional history: | |

## Language History

| | |
|---|---|
| Child's Primary Language | |
| Other Language Exposure | |

## Educational History

| | | |
|---|---|---|
| Current school | | |
| Previous school(s) (include preschool) | | |
| Highest grade completed | 1 2 3 4 5 6 7 8 9 10 11 12 | Current Grade: |

| Does child receive any special services at school? | **YES** | **NO** | **If so, what services are received?** |
|---|---|---|---|
| | | | |

## Additional information

| Other information you would like us to know about your child: | | |
|---|---|---|
| *Primary Care Physician* | | |
| Name | Address | Phone |

**ILLNESSES/HEALTH CONDITIONS/CONCERNS:**

Please check if your child has had any of the following:

- ❑ allergic reactions
- ❑ always congested
- ❑ asthma
- ❑ bronchitis/bronchiolitis
- ❑ bronchoscopy
- ❑ cancer/tumor
- ❑ cleft lip/palate
- ❑ constipation
- ❑ ear infections
- ❑ failure to thrive
- ❑ floppy airway
- ❑ frequent colds
- ❑ head injury
- ❑ heart problems
- ❑ hospitalization
- ❑ infection (meningitis, encephalitis)
- ❑ pneumonia
- ❑ reflux
- ❑ respiratory syncytial virus (RSV)
- ❑ seizures
- ❑ stridor/noisy breathing
- ❑ surgeries
- ❑ tonsillitis
- ❑ tracheoesophageal fistula
- ❑ tracheostomy
- ❑ turned blue/quit breathing
- ❑ upper respiratory infections
- ❑ other______________________

**FEEDING HISTORY:**

1. Has your child had a swallow study or feeding evaluation before this appointment? If so, when:_________________

   Where: _______________________________ Results: ___________________________________

   Recommendations:__________________________________________________________________

   ______________________________________________________________________________

2. Has your child been seen by a dietician or nutritionist? If so,

   when:_________________________________________

   Where:_________________________________

   Results_________________________________________________

   Recommendations:__________________________________________________________________

   ______________________________________________________________________________

2. As an infant, my child was: ❑ bottle fed ❑ breast fed ❑ both ❑ other

   Comments:_______________________________________________________________________

3. Did your child immediately latch onto bottle/breast? ❑ Yes ❑ No

   Comments:_______________________________________________________________________

4. Did your child require a special nipple? ❑ Yes ❑ No

   Comments:_______________________________________________________________________

5.

| AGE WHEN INTRODUCED | TYPE OF FOOD | CHECK ONE | |
|---|---|---|---|
| | Baby Cereals | ❑ REFUSED | ❑ ACCEPTED |
| | Baby food: Stage 1 | ❑ REFUSED | ❑ ACCEPTED |
| | Baby food: Stage 2 | ❑ REFUSED | ❑ ACCEPTED |
| | Baby food: Stage 3 | ❑ REFUSED | ❑ ACCEPTED |
| | Mashed food (banana, potato) | ❑ REFUSED | ❑ ACCEPTED |
| | Table food: Meat | ❑ REFUSED | ❑ ACCEPTED |
| | Table food: Vegetables | ❑ REFUSED | ❑ ACCEPTED |
| | Table food: Fruits | ❑ REFUSED | ❑ ACCEPTED |
| | Table food: Pasta | ❑ REFUSED | ❑ ACCEPTED |

**FEEDING BEHAVIOR:**

1. Where does your child sit during meal times?

   ❑ infant seat ❑ child stands
   ❑ high chair ❑ child wanders around
   ❑ held in caretaker's arms ❑ on caretaker's lap
   ❑ booster seat ❑ other:___________________________________
   ❑ regular chair

2. With whom does your child usually eat? ❑ alone ❑ family ❑ other

3. Does your child exhibit any of the following behaviors during feeding?

   ❑ breathing problems ❑ gurgly, wet voice sounds
   ❑ coughing ❑ sneezing & runny eyes
   ❑ color changes ❑ spitting food out/refusing food
   ❑ congestion ❑ vomiting
   ❑ crying ❑
   other:________________________________________
   ❑ gagging

   **If any checked, please explain:** ____________________________________________________________

4. How long does a mealtime last for your child?_____________________________________________________

**CURRENT FEEDING SKILLS:**

1. Your child's appetite is best described as:

   ❑ Poor ❑ Fair ❑ Good ❑ Excellent

2. Does your child tell you when they are hungry? ❑ Yes ❑ No

   How: ___________________________________________________________________________________

3. Check the items that describe your child:

   ❑ Drinks from bottle ❑ Drinks from cup/glass
   ❑ Fed by caregivers ❑ Drinks from straw
   ❑ Feeds self with fingers ❑ Pours own drink
   ❑ Feeds self with spoon ❑ Prepares own snack
   ❑ Feeds self with fork ❑ Uses knife

4. Please check the box that best describes your child:

| | REFUSES/ AVOIDS | TOLERATES/ ACCEPTS | PREFERS/ CRAVES | AGE WHEN INTRODUCED |
|---|---|---|---|---|
| Smooth (pudding, yogurt) | | | | |
| Baby food (please specify stage: _________________) | | | | |
| Chewy (dried fruit, bagel, meat) | | | | |
| Crunchy (crackers, pretzels) | | | | |
| Mixed textures (yogurt with fruit, cereal with milk, spaghetti) | | | | |
| Mashed table foods (potatoes, cooked vegetables, fruit) | | | | |
| Chopped table food | | | | |
| Pureed/blenderized table food | | | | |
| Regular table food | | | | |

5. Please check which taste your child prefers:

   ❑ Spicy ❑ Mild/Bland ❑ Sour ❑ Sweet ❑ Salty

6. Please check which temperature your child prefers:

   ❑ Hot ❑ Cold ❑ Room Temperature

**OTHER SENSORY:**

1. Is your child sensitive to certain sounds that would not bother other peers (ie. blender, microwave, saliva)?

   ______________________________________________________________________________

2. Is your child sensitive to touchy messy substances including foods of certain textures?

   ______________________________________________________________________________

3. Does your child dislike certain smells of foods?

   ______________________________________________________________________________

**Please circle ALL foods you child eats as part of his/her regular diet.**

| Categories | Foods | Comments |
|---|---|---|
| **Meats:** | Hot Dogs Chicken Nuggets Chicken Strips Sausage Fish sticks Pepperoni Ground Beef Burger Bacon Lunch Meat: Turkey/ Ham/ Chicken Eggs: fried/ scrambled/ hard boiled<br>Other:<br>Brands: | |
| **Fruits:** | Apple Banana Orange Watermelon Pear Mango Cantaloupe Honeydew Cherries Blueberries Raisins Pineapple Peaches: canned/ fresh Strawberries Grapes Raspberries Dried Fruit Freeze Dried Crasins Kiwi Plum Blackberries<br>Juice: apple/ orange/ fruit punch/ grape/ V8<br>Other: | |
| **Veggies:** | Carrots Green Beans Peas Peppers – G, R, Y<br>Tomato Broccoli Corn Sweet Potato Asparagus Mushrooms Spinach Freeze Dried Cucumber Squash Beans: Black/ Kidney/ Green<br>Potatoes: Mashed/ French Fries/ Hashbrowns/ Scalloped<br>Other: | |
| **Purees:** | Yogurt (flavors): Greek/ YoBaby/ Reg<br>Pudding: choc/ Vanilla Jell-O Applesauce Ice cream Smoothie Milkshake Crushers Hummus Jelly Peanut Butter Baby Food (Stage 1 2 3) Flavors:<br>Other: | |
| **Snacks:** | Cheerios Other Cereal:<br>Crunchy/ Goldfish Crackers Veggie Sticks Veggie Chips Chewy Popcorn Chips Pretzels Granola bars Fruit snacks Fruit Leather Cheetohs Veggie Bootie Raisins Cheezits Graham Crackers Pita chips<br>Other:<br>Brands: | |
| **Breakfast:** | Waffles Pancakes French Toast Toast Bagel Cereal with Milk English Muffin Bread Oatmeal Cereal Bar Muffin<br>Other: | |
| **Meals:** | Grilled cheese sandwich PBJ sandwich Soup Chili Macaroni and cheese Spaghetti Ravioli Noodles Taco/ quesadilla Pizza: cheese/toppings Lasagna Rice<br>Other sandwiches:<br>Other:<br>Brands: | |
| **Diary:** | Cottage Cheese Cheese Yogurt Milk<br>Other: | |
| **Condiments/ Dips:** | Ketchup Ranch Mustard Cheese BBQ Sauce Tomato Sauce Syrup Hummus Honey Butter<br>Other: | |

| Sensory Preference | | |
|---|---|---|
| **Texture** | Crunchy Chewy Soft Hard Mushy | |
| **Taste** | Bland Sour Sweet Salty Spicy | |
| **Temperature** | Cold Hot Warm | |
| | No Preference | |

Other Comments:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

# THREE DAY FOOD JOURNAL

Please use the space below to monitor daily food and liquid intake, and to record any problems. Be sure to include all items consumed – include the item name, quantity, texture, and any observed behavior. Complete one page per day for a total of three days. Sample page is included as a reference below.

## SAMPLE FOOD JOURNAL

| Day 1 | Food and Approximate Amount | Observations/Comments |
|---|---|---|
| Breakfast | Cereal – small bowl<br>Fruit (1 banana, medium)<br>Sippy cup of milk | Spit out fruit.<br>Threw other half on floor. |
| Snack | Gerber puffs (10) | No problem observed |
| Lunch | 1 jar stage 2 peas<br>Pasta pick-ups (1) container<br>Applesauce<br>Juice box | Coughed on Pasta pick-ups<br>Eyes watered<br>Squirmy |
| Snack | None | None |
| Dinner | Gerber graduates ravioli (2)<br>Open cup milk | Wandering around kitchen.<br>Picking up one at a time with fingers/refused utensil. Dribbling down mouth/face. |
| Snack | Bottle (6 oz.) | Fell asleep in Dad's arm half way through. |

## DAY ONE

Continue your record of daily food and liquid intake.

| Day 1 | Food and Approximate Amount | Observations/Comments |
|---|---|---|
| | | |

## DAY TWO

Continue your record of daily food and liquid intake.

| Day 2 | Food and Approximate Amount | Observations/Comments |
|---|---|---|
| | | |

## DAY THREE

Continue your record of daily food and liquid intake.

| Day 3 | Food and Approximate Amount | Observations/Comments |
|---|---|---|
| | | |

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## Informed Consent and Authorization for Services
## Authorization to Use, Obtain, and / or Disclose Protected Health Information

**Consumer Name:** ______________________________ **Birth Date:** ____________________

### Consent for Services

I hereby authorize, consent, and direct TLC - The Treatment and Learning Centers, or its agents, officers, employees, and representatives to use procedures, methods, and materials that it deems prudent, reasonable, and appropriate to provide the requested services indicated below.

### Authorization to Use, Obtain and / or Disclose Protected Health Information

I authorize my TLC professional and / or administrative staff to Use, Obtain, and / or Disclose the following protected health information.

**Select the Service to be provided and / or the Protected Health Information to be used, obtained and/or disclosed**
**(check all that apply)**

- ☐ Audiology
- ☐ Occupational/Physical Therapy
- ☐ Speech-Language Therapy
- ☐ Medical
- ☐ Tutoring/Coaching
- ☐ Educational
- ☐ Psychological
- ☐ Other: (describe) ____________________

### Type of Information (check all that apply)

I further authorize TLC to use, obtain and / or disclose Protected Health Information in the following form(s):

| | | | | |
|---|---|---|---|---|
| ☐ Written | ☐ Verbal Exchange | ☐ Video / Audio Records | ☐ Text Message | ☐ Other: |
| ☐ Fax | ☐ Voice Mail | Email Yes ☐ No ☐ (see page 2 if you checked Yes) | | |
| | | Email: | | |

I authorize TLC to exchange information with the following:

| NAME | FULL ADDRESS [Include PHONE, if applicable] |
|---|---|
| **Self/Parent** [*you must be listed if you want a copy of reports*]: | |
| **Physician:** | |
| **School or Funding Agency**: | |
| **Other:** | |

***TURN OVER, PLEASE***

This protected health information is being used or disclosed at your request for follow-up by participating professionals, and / or for insurance / reimbursement purposes, and research. (If used for research, no identifying information will be released.)

I hereby release TLC, its agents, officers, employees, and representatives from legal responsibility or liability for services provided or information released pursuant to this Authorization.

**NOTE REGARDING INSURANCE:** TLC is **not** a participating provider with any HMO, PPO, or POS, or any other INSURANCE plan except for the following:

(1) CIGNA **(occupational therapy, physical therapy, speech therapy, and audiology)**
(2) United Healthcare **(audiology only)**
(3) Medicare **(audiology only)**.

I authorize TLC to submit claims for plan-eligible services to my insurance carrier; TLC will submit claims to the listed plans only. I understand that I will be required to pay copayments, amounts applied to deductibles, and any charges not paid in accordance with the benefits of the insurance plan in effect at the time services are rendered. In the event of nonpayment of submitted claims, I agree to pay the full billed charges for all services rendered.

I understand that I have the right to revoke this authorization at any time by sending written notification to

**Director of Administrative Services, TLC**
**2092 Gaither Road, Suite 100**
**Rockville, MD 20850**

Unless revoked in writing, this authorization shall be in force and effect for 1 year from the date of this document, at which time this authorization to use and / or disclose this protected health information will expire.

## ACKNOWLEDGEMENTS

**EMAIL CONSENT NOTICE** (If you checked Yes to email on page 1)

Your signature below is your request to communicate personally identifiable information concerning your / your child's services by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the Client or other responsible party.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

### Acknowledgement and Agreement

I acknowledge that I have read and understand the items above that describe the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I authorize TLC – The Treatment and Learning Centers and members of my treatment team to communicate with me at my e-mail address concerning services provided to me / my child, including but not limited to, communication regarding service delivery, my / his / her progress towards goals, and any other related matters. I

understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

I further agree that I will not use e-mail to communicate with TLC, and will use other means of communication (e.g., telephone, in-person visit, etc.) for the following:

- Emergencies or other time-sensitive issues that require immediate action
- Inquiries that deal with sensitive information
- Situations in which TLC does not / is unable to respond to an e-mail communication (e.g., offices closed, power outage)

I understand that TLC will make a reasonable attempt to return all e-mail messages received within two (2) business days; however, if I do not receive a response by the close of business on the second business day following my e-mail communication, I agree to use other means of communication to contact TLC. I further understand that e-mail communications with TLC is offered as a convenience to me, and agree to not hold TLC responsible for any expense, loss, or damage caused by or resulting from the following:

- A delay in TLC's response, or any damage to me / the Client resulting from such delay, including, but not limited to the following: therapist absence, therapist inability to respond, technical failures attributable to TLC's internet service provider, power outages, failure of TLC's electronic messaging software, failure by TLC or me / the Client to properly address e-mail messages, failure of TLC's computers / computer network, or faulty telephone / cable data transmission
- Any interception of my or TLC's e-mail communications by a third party
- My failure to comply with the guidelines regarding use of e-mail communications set forth above

**HIPAA PRIVACY NOTICE**

By signing this form, you acknowledge that The Treatment & Learning Centers / KTS has provided you access to a copy of its HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this acknowledgement on your first date of service with us.

The Practice has provided me access to its Privacy Notice. I understand I may request a copy of this Privacy Policy for my personal use.

**GENERAL ACKNOWLEDGEMENT**

I acknowledge that I have read, understand, and agree to the contents of this document.
I understand and agree to the policies, procedures and fees related to the services that I have requested.

________________________________________ ____________________

Signature of Person Receiving Services or Legal Representative Date

________________________________________

Relationship to Person Receiving Services

This Page intentionally left blank

2092 Gaither Road, Suite 100
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TTY 301.424.5203
www.ttlc.org

Date: ___________________________

Dear Consumer,

Because we are a nonprofit that accepts government funding and foundation grants for some of our services, we are asked to keep certain demographic statistics about the clients we serve.

Your answers to the question below are totally voluntary and confidential. This form will not be a part of, nor ever identified with, the consumer's file.

Thank you for your assistance.

Consumer Ethnic Background:

Native American: __________

Asian: __________

White: __________

Pacific Islander: __________

Black/African American: __________

Hispanic/Latino: __________

Other Ethnicity: __________

Two or more races: __________

Reviewed/Revised: 11/14
G:\Word Processing\ALL TLC STAFF\Bobrow\2014\Letters\Consumer DEMOGRAPHICS Letter November 2014.Doc

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# SPEECH-LANGUAGE and HEARING DEPARTMENT PHYSICIAN'S REFERRAL FORM

**I. Patient Name:** ______________________________

Patient Birthdate: ______________________________

Patient Address: ______________________________

______________________________

Patient Phone: (H) ______________ (W) ______________

**II. Reason for Referral:** ______________________________

______________________________

**III. Pertinent Medical History:** ______________________________

______________________________

Medications: ______________________________
(dosage & frequency) ______________________________

Previous Testing: ______________________________

Contraindications/Precautions: ______________________________

______________________________

Date of Last Examination: ______________________________

Date of Return Visit: ______________________________

**IV. Services Desired:** Speech-Language: ____________ Audiology: ____________

Evaluation Only: ____________ Evaluation & Appropriate Intervention: ____________

Suggested Treatment Goals: ______________________________

______________________________

______________________________

Are there any medical contraindications for the use of amplification or therapeutic Intervention, if recommended? Yes: ____________ No: ____________

**V. Physician Authorization:**

Signature: ______________________________ M.D.

Print Name: ______________________________

Telephone: ______________________ Date: ____________

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