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

OUTPATIENT SERVICES – CHILD CASE HISTORY FORM

Child Information

Date

Name / Gender	Name		Gender ☐ M ☐ F
Date of Birth / Age / School	Date of Birth	Age	Grade / School
Home Address	Street		Apartment
	City	State	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

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?				
What were baby's APGAR scores?				
Other:				
Infancy				
Were there any feeding problems?				
Did baby exhibit average activity level?				
During the first several months of life, was baby's health good?				
Other:				
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:		

Gross and Fine Motor	**YES**	**NO**	**N/A**	**Additional Information**
Is there a history of problems with gross motor skills (walking, running, climbing)?				
Are there currently any problems with gross motor skills?				
Is there a history of problems with fine motor skills (e.g., picking up objects, dressing)				
Are there currently any problems with fine motor skills?				
Which hand does child use most often?				❑ Left ❑ Right ❑ Uses both hands equally

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 ❑ Sounds + gestures ❑ Single words ❑ Series of single words (pauses between words) ❑ Single words + short phrases ❑ Complete / grammatically <u>incorrect</u> sentences ❑ Complete / grammatically CORRECT sentences ❑ 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 ❑ Poorly understood ❑ 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 ❑ "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 104° or more?				
Is child currently under treatment for any medical condition?				
Are there any problems with vision?				
Has child had vision screened or tested?				Results:
Does child wear corrective lenses for vision?				
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 Services**	**Agency/Person**
Educational / Psychological Testing				
Hearing / Audiology Evaluation				
Occupational Therapy Evaluation				
Physical Therapy Evaluation				
Speech Language Evaluation				

Current and/or Previous Therapy (List All)	YES	NO	Dates of Services	Agency/Person
Counseling				
Occupational Therapy				
Physical Therapy				
Speech Language Therapy				
Tutoring				

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:

Social and Emotional History

Behaviors	YES	NO	N/A	Additional Information
Is child more interested in objects than people?				
Does child demonstrate self-stimulating behaviors?				❑ Rocking ❑ Arm Flapping ❑ Hand movement ❑ Other:
Does child demonstrate head-banging?				
Does child "give up" easily?				
Does child exhibit ritualistic or compulsive behaviors?				
Does child engage in behaviors that are dangerous to self or others?				
Other:				

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		

Behavior	Age (from – to)	Strategies Used to Address Behavior
Physically strikes out at others		
Shyness		
Sleeplessness		
Strong fears – nightmares		
Temper tantrums		
Thumb sucking		

Please answer the following questions regarding your child's behavior.			
What types of activities or toys does your child prefer?	Please describe:		
Does your child play with other same-age peers?	**YES** ☐	**NO** ☐	Please describe:
Are you ever concerned that your child doesn't play well with other children?	**YES** ☐	**NO** ☐	Please describe:
Do you feel that your approach to discipline is effective?	**YES** ☐	**NO** ☐	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	
Age at which other Language(s) Introduced	
Where (e.g., Home, Daycare, or School)?	
Who Speaks other Language?	
Child is able to	❑ Speak _____ ❑ Understand _____ ❑ Write _____ ❑ Speak _____ ❑ Understand _____ ❑ Write _____

Educational History

Name of public school district where child lives				
Current school				
Previous school(s) (include preschool)				
Highest grade completed	1 2 3 4 5 6 7 8 9 10 11 12			Current Grade:
Has child ever repeated a grade?	**YES**	**NO**	**Please describe, including grade(s) repeated**	
Are there any current concerns regarding school performance?	**YES**	**NO**	**Please describe**	
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

Person Completing this Form	
Relationship to the Child	

Signature: _____ **Date:** _____

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OCCUPATIONAL THERAPY SERVICES

Child's Name _____ Birthdate _____ Date _____
Parents' Names _____Telephone _____
Parents' Address _____

Handedness of family: Mother R L; Father R L; Brothers or Sisters R L, R L, R L;
Grandparents R L, R L, R L, R L; Preferred hand of child: R L

	Yes	No	Sometimes
DRESSING			
Child is completely independent in all areas of dressing (If no, please specify)			
1. Assist in dressing (offers arm or leg; pulls shirt overhead)			
2. Takes off clothes			
3. Knows front from back			
4. Puts on shirt over head			
5. Puts on pants independently			
6. Independently manages _____ buttons _____ zippers _____snaps			
7. Takes off socks and shoes			
8. Puts on socks			
9. Puts on shoes			
10. Shoes on correct feet			
11. Ties shoes			
FEEDING			
1. Drinks without spillage			
2. Handles spoon well			
3. Uses fork			
4. Uses knife			
5. Sucks through straw			
6. Swallows liquids well			
7. Swallows solids well			
8. Chews with mouth closed			
MOTOR			
1. As an infant – creeping and crawling phase was brief/absent			
2. As an infant – sat, stood, or walked late			
3. Movements are slow and plodding			
4. Seems clumsy – tends to bump into or trip over things often			
5. Can ride a tricycle			
6. Can ride a two-wheeler			
7. Has difficulty pumping on swings			
8. Able to kick a ball			
9. Dislikes or has difficulty with coloring and cutting			
10. Shies away from puzzles and manipulative toys			
11. Manipulative hand skills (use of spoon, cup, pencil) difficult for him/her			
12. Has difficulty holding pencil or crayon in three-point position			
13. Misunderstands the meaning of words in relation to movement			
14. Has difficulty playing with new toys			
15. Has difficulty maintaining posture while sitting in chair			

	Yes	No	Sometimes
16. Walks on toes			
17. Takes longer to learn new task			
MOVEMENT/VESTIBULAR			
1. Loses balance easily			
2. Fearful/Resists challenges to balance			
3. Gets carsick often			
4. Gets nauseous and vomits from other movement experiences			
5. Is unable to give adequate warning about these feelings			
6. Seeks an unusual amount of twirling or spinning			
7. Does not seem to get dizzy from such activities			
8. Thrill seeker/Risk taker on playground			
9. Hesitates to climb or play on moving playground equipment			
10. Between the ages of six months and two years, tended to stiffen or cry when held or moved			
11. Disliked rough play as a toddler (horsey or piggy-back rides, somersaults, Being tossed in the air, etc.)			
12. Had trouble or hesitancy in learning to climb or descend stairs			
13. Avoids activities where feet leave the ground; fearful of climbing			
TOUCH/PROPRIOCEPTION			
1. Touches everything; can't keep hands to self			
2. At times seems unaware of being touched			
3. Seems almost unaware of or "stoic" over painful experiences, such as having shots, stitches, or dental work			
4. Often unaware of bruises, cuts, etc.			
5. Tends to push too hard with pencils or crayons (frequently breaking them)			
6. Tends to be too rough with small, fragile toys			
7. Touches pets and other children too roughly			
8. Overdresses, seeming to be unaware of summer heat			
9. Underdresses; seeming to be unaware of cold weather/temperature			
10. As a baby, disliked being touched, cuddled, or handled			
11. Currently dislikes being touched, cuddled, or handled			
12. Seems excessively ticklish			
13. Negative reaction to unexpected touch			
14. Avoids getting hands in finger paints, paste, sand, etc.			
15. Dislikes going barefoot, even for brief periods			
16. Avoids/Irritated by certain kinds of clothing or material (name)			
17. Avoids certain food textures: _____ chewy _____ crunchy _____rough _____ mushy			
18. Does not like to brush teeth			
19. Strongly dislikes showers or outdoor sprinklers			
20. Extra sensitive to being hit by others			
21. Overly sensitive to bath temperature			
22. Rubs or scratches self often for no apparent reason			
VISUAL			
1. Highly distracted by visual stimuli			
2. Has poor attention span at school			
3. Makes reversals when copying			
4. Makes reversals when writing or drawing from memory			
5. Reverses sequential order, e.g., writes "14" by writing the 4 and then putting the 1 in front of it			
6. Confuses letters such as "b" and "d"			

	Yes	No	Sometimes
7. Often loses place when reading and copying			
8. Complains of words or objects moving on the page			
9. Has difficulty remembering where things are kept in the house			
10. Frequently gets lost or has difficulty getting around the neighborhood			
11. Difficulty catching a tossed ball			
12. Dislikes when vision is occluded (being in the dark, shirt being pulled over his/her head, dark play areas)			
AUDITORY			
1. Has had recurring ear trouble (explain below)			
2. Particularly distracted by sounds, especially sounds that go unnoticed by others (i.e., air conditioner, humming of a fan, ticking of a clock)			
3. Often fails to listen or pay attention to what is said to him/her			
4. Often fails to act upon requests or has trouble understanding directions			
5. Unable to follow a two- or three-step activity if instructions are given all at once			
6. Talks excessively			
7. Talking by others stimulates him/her to be overly verbal			
8. Frightened by some sounds not normally alarming to other children the same age (sirens, phone ringing, vacuum, toilet flushing)			
9. Speech development was delayed			
10. Hums, sings softly to self, “self-talks” through tasks			
SOCIAL/PLAY			
1. Finds it hard to make friends among peers			
2. Prefers company of adults or older children who allow more room for his/her mistakes			
3. Tends to play with children one or two years younger			
4. Frequently expresses feelings of frustration or failure			
5. Tends to be a loner			
6. Often discouraged and depressed			
7. Plays with toys inappropriate for his/her age			
8. Has difficulty engaging in prolonged play of his/her own volition			
9. Is overly rough and aggressive when playing			
10. Does not understand concepts of make-believe			
11. Laughs or cries too easily or inappropriately			
12. Tends to rock or fidget often			
13. Difficulty with changes in routines			
14. Does not respond well to new or unfamiliar situations			
15. Difficulty initiating/asserting self into group play			
OLFACTORY-GUSTATORY-ELIMINATION-SLEEP PATTERNS			
1. Appears unusually sensitive to smells			
2. Prefers/craves certain food/tastes: _____ spicy _____bland _____salty _____ sweet _____ sour			
3. Wet bed after three years of age			
4. Had trouble learning urinary control			
5. Had trouble learning bowel control			
6. Had irregular sleep patterns as an infant			
7. Has irregular sleep patterns now			
8. Experiences frequent nightmares			

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The Treatment and Learning Centers TLC

OCCUPATIONAL THERAPY
CLASSROOM OBSERVATION CHECKLIST

(To be completed by classroom teacher)

Date_____

Student's Name _____ Parent's Name _____

Birthdate _____ Address _____

School _____ _____

Grade _____ Telephone _____

Teacher's Name _____

Is student being seen by other specialists (Resource, Speech, etc.)?

Please check appropriate box:

	below grade level	**at grade level**	**above grade level**
Reading			
Arithmetic			
Spelling			
Writing			

The following is a list of symptoms or signs that may indicate deficits in sensory integration (the ability to process past and present sensory information enabling one to interact effectively with the environment). Please check the frequency of these behaviors. A great deal depends on the combination of factors.

	Seldom	**Sometimes**	**Often**
I. Postural and Gross Motor			
1. Muscles seem weak and floppy			
2. Muscles seem tight and rigid			
3. Unusual walking pattern (dragging feet, stiff, limps, falls often, Runs rather than walks)			
4. Poor posture (pot belly), round shoulders, forward curve of spine, works with head on desk)			
5. Tires easily			
6. Gross-motor tasks (i.e., skipping, jumping, hopping, running) are awkward as compared to peers			
II. Fine Motor			
1. Difficulty manipulating small objects (pegs, beads)			
2. Difficulty using scissors, coloring, or fastening clothing			
3. Abnormal pencil grip (___immature; ___tight; ___weak; ___tires easily)			
4. Jerky or tremor-like motions in hands when drawing			
5. Difficulty staying on line when tracing			
6. Eyes do not guide hands, but seem to wander			

III. Basic Sensory Functioning (Touch, Movement, Muscle, and Joint Sensations)			
1. Pushes, shoves, kicks when standing in lines or crowds			
2. Dislikes being touched; prefers touching others			
3. Craves touch			
4. Difficulty identifying objects by touch alone			
5. Excessive mouthing of objects			
6. Cannot find body parts with eyes closed			
7. Fearful of movement			
8. Never gets dizzy (craves spinning and rocking; doesn't seem to get dizzy)			
9. Gets dizzy easily (avoids rolling and spinning)			
IV. Auditory			
1. Needs to have instructions repeated or said slowly			
2. Does not respond to sounds outside range of vision			
3. Mishears words (i.e., *pin* for *pen*, *busy* for *dizzy*)			
V. Visual Perception			
1. Poor understanding of spatial concepts (large, small, and numbers)			
2. Poor directional concepts (up, down, right, left, in, out, before, behind)			
3. Bumps into chairs or desks often			
4. Constant or unusual eye movements (describe _____ _____			
5. Difficulty putting puzzles together which offer no problems to peers			
6. Difficulty recognizing shapes			
7. Difficulty sequencing			
8. Difficulty identifying relevant stimuli from distracting background			
9. Poor spacing of work on paper			
10. Fatigues easily with visual tasks such as reading			
11. Reverses letters, numbers, words, or phrases			
12. Omits words and phrases, skips lines, and loses his place while reading or copying			
VI. Bilateral Integration			
1. Avoids or has difficulty performing tasks which require eyes or extremities to cross midline of body (e.g., tends to keep work on one side of midline, switches objects to opposite hand when working on that body side, pivots body to avoid crossing the midline)			
2. Neglects or seems unaware of one side			

3. Doesn't stabilize paper while writing			
4. Seems to ignore half of a page			
5. Inconsistent hand dominance			
6. "Always" uses both hands together			
VII. Learning Behavior			
1. Unable to attend to task as long as classmates			
2. Easily distracted			
3. Wiggles a lot; can't sit still			
4. Talks out in class, sings, hums, etc.			
5. Appears to have difficulty comprehending what's going on around him			
6. Can't tolerate change in routine			
7. Difficulty recognizing own errors			
8. Difficulty working independently			
9. Perseverates			
10. Disorganized, messy			
11. Slow worker			
12. Rushes through work			
VIII. Social-Emotional			
1. Behavior--annoys or bothers others			
2. Verbally aggressive—bosses, swears, threatens			
3. Physically aggressive—in fights often			
4. Happiest playing alone			
5. Is attention-seeking			
6. Fearful of new situations			
7. Impulsive			
8. Lacks confidence (often says "I can't" or "It's too hard")			
9. Easily frustrated			
10. Cries easily			
11. Falls asleep during class			
12. Physical complaints (headaches, stomachaches)			
13. Can't calm down; can't stop brooding when upset			

IX. Comments or Additional Observations:

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

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

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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: _____ Black/African American: _____

Asian: _____ Hispanic/Latino: _____

White: _____ Other Ethnicity: _____

Pacific Islander: _____ Two or more races: _____

Reviewed/Revised: 11/14
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OCCUPATIONAL THERAPY PHYSICIAN'S REFERRAL FORM

Date: _____

I. Client Name: _____ _____
Address: _____
Telephone: (H) _____ (W) _____
Client Birthdate: _____

II. Reason for Referral: _____

III. Pertinent Medical History:
Medications: _____
Previous Testing: _____
Precautions/Contraindications: _____
Date of Last Exam: _____ Date of Return Visit: _____

IV. SERVICES DESIRED: ☐ Evaluation Only ☐ Evaluation & Treatment

Standardized Evaluations:

☐ Range of Motion ☐ Muscle Strength ☐ Gross & Fine Motor Coordination

☐ Visual-Motor & Visual Perception ☐ Hand Function

Functional Performance Assessment:

☐ Sensory-Perceptual Integration Assessment ☐ Self-Care Assessment

☐ Adaptive Equipment Assessment & Training ☐ Home Assessment

Comprehensive Developmental and/or Neuromotor Assessment:

☐ (Includes: Neuro-muscular status, sensory perception, gross and fine motor, visual motor-perception, cognition, self-care, oral motor, and play/leisure skills and prevocational management)

Single Service: *

☐ Develop Home Program ☐ Splinting ☐ Adaptive Equipment & Training ☐ Other

*Special Instructions:

V. PHYSICIAN AUTHORIZATION: Signature: _____ M.D.
Print Name: _____
Telephone: _____ Date: _____