LAMAR UNIVERSITY

# CASE HISTORY: CHILD
# SPEECH-LANGUAGE PATHOLOGY

**General Information:**

Patient's Name: _____Date Of Birth: _____

Guardian: _____Relationship:_____Occupation:_____

Daytime Phone: _____ E-Mail: _____

Guardian: _____Relationship:_____Occupation:_____

Daytime Phone: _____ E-Mail: _____

Referred By: _____

Pediatrician: _____Phone: _____

Person completing form: _____Relationship:_____

Signed: _____ Date:_____

Does the child live with both parents? _____ If no, who does the child live with? _____

_____

Brothers and Sisters (include names and ages): _____

_____

Additional people who live in the home: _____

What languages does the child speak?_____

What languages are spoken in the home?_____

With whom does the child spend most of his/her time? _____

_____

We try to provide positive reinforcement during the evaluation in the form of favorite snacks and/or beverages. If this is permissible please provide the following information:

FAVORITE SNACK:_____ BEVERAGE: _____

ALLERGIES TO ANY FOODS: _____

PLEASE BRING FAVORITE TOY OR ANYTHING THAT WOULD MAKE HIM/HER FEEL MORE COMFORTABLE AND SEPARATE MORE EASILY FROM PARENT/GUARDIAN.

What activities, hobbies, or games does the child enjoy? _____

_____

_____

Describe the child's speech-language problem. _____

_____

_____

_____

How does the child usually communicate (gestures, single words, short phrases, sentences)?

_____

_____

How does the child interact with others (e.g. shy, aggressive, uncooperative, etc.)?_____

_____

_____

When was the problem first noticed? _____By whom?_____

What do you think may have caused the problem? _____

_____

_____

_____

Has the problem changed since it was first noticed? _____

_____

_____

Is the child aware of the problem? _____ If yes, how does he/she feel about it?_____

_____

Have any other speech-language specialists seen the child? _____ Who? _____

When?_____ What was their conclusion or suggestions? _____

_____

_____

Have any other specialists (physicians, psychologists, audiologist, neurologist, special education teachers, etc.) seen the child? _____

When was the child was seen?_____, The specialist's conclusions or suggestions:_____

_____

_____

Are there any other speech, language, or hearing problems in your family?_____ If yes, please describe:

_____

_____

_____

**Medical History:**

Mother's general health during pregnancy (illnesses, accidents, medications, etc.):_____

_____

_____

Circle type of delivery: Head First Breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth? (e.g., RH incompatibility, jaundice, anoxia, length of pregnancy or labor, birth weight, etc.)_____

_____

_____

Provide the approximate age the child suffered the following illnesses and/or conditions:

_____ Allergies _____Asthma _____Chicken Pox _____Colds _____Convulsions

_____ Croup _____Dizziness _____ Draining Ear _____ ADHD _____Ear Infection

_____ CMV _____Herpes _____German Measles _____HIV _____ Headaches

_____ Measles _____Seizures _____Visual Problems _____ Mumps _____ Hearing Problems

_____ Influenza _____ Sinusitis _____Hepatitis A or B _____ Meningitis _____Encephalitis

_____Tinnitus _____High Fever _____Mastoiditis _____Tonsillitis _____Heart Problems

_____TB _____Paralysis _____Cleft lip or palate _____Pneumonia _____ Respiratory Problems

Other_____

Has the child had any surgeries?_____ If yes, what type, when and by whom (e.g., tonsillectomy, adenoidectomy, etc.)? _____

_____

Describe any major accidents or hospitalizations. _____

_____

What is the child's current health status?_____

_____

Is the child taking any medications?_____If yes, identify:_____

_____What for?_____

Have there been any negative reactions to medications?_____

If yes, identify._____

_____

**Developmental History:**

Provide the approximate age at which the child began to do the following activities:

_____Crawl _____ Sit Unassisted _____ Stand _____Walk _____Feed Self
_____ Dress Self _____Use toilet
Use single words (e.g. no, mom, daddy, doggie, etc.):_____
Combine words (e.g. me go, daddy shoe, etc.): _____
Name simple objects (e.g. dog, car, tree, etc.):_____
Use simple questions (e.g. Where's doggie? etc.):_____
Engage in a conversation:_____

Does the child have difficulty walking, running, or participating in other activities which require small or large

muscle coordination? _____

_____

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling,

chewing, etc.)? _____If yes, describe. _____

_____

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently

responds to sounds, etc.)._____

_____

_____

**Educational History:**

School/District:_____Grade:_____

Teacher(s):_____

How is the child doing academically (or pre-academically)? Please check one.

Excellent _____ Average_____ Below Average_____

Does the child receive special services? _____If yes, describe.

_____

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? _____

If yes, describe the most important goals. _____

_____

_____

_____

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

_____

_____

_____

_____

College of Fine Arts & Communication
LAMAR UNIVERSITY™
Department of Speech & Hearing Sciences

Name: _____

## LIST OF CURRENT MEDICATIONS:

**List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).**

| Medication (Brand and Generic Name) | Dose | How and How Often You Take the Medication | Reason for taking | Date Started | Prescriber |
|---|---|---|---|---|---|
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**Check here if additional pages of medicine list attached [ ]**



Date Updated: _____

College of Fine Arts & Communication
LAMAR UNIVERSITY™
Department of Speech & Hearing Sciences

Name: _____

## Continuation of List of Current Medications

Page _____ of _____

**List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).**

| Medication (Brand and Generic Name) | Dose | How and How Often You Take the Medication | Reason for taking | Date Started | Prescriber |
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Date Updated: _____

COLLEGE OF FINE ARTS & COMMUNICATION
LAMAR UNIVERSITY™
Department of Speech & Hearing Sciences

**Release of Information**

Patient Name:_____ DOB:_____

Guardian:_____ Relationship to Patient:_____

Address:_____ City:_____ ZIP:_____

I hereby authorize and grant Lamar University Speech and Hearing Clinic permission:

1. To release/receive confidential/diagnostic information concerning the above named patient to assist in evaluation and planning his/her treatment management program.
2. To release documentation to primary care physicians and any referring provider in order to maintain continuation of care.
3. To record the voice and image of the above named patient. I understand the material recorded may be used for educational, informational, training, and/or research purposes. However, without personally identifying the patient by name.
4. To use such diagnostic, therapeutic/ management and motivational procedures as the Clinic Director, Supervisors, and Clinicians deem necessary and appropriate.
5. To utilize Graduate Clinicians in the delivery of evaluation and/or treatment programming.
6. To utilize data collected during appointments for research purposes.
7. To contact the patient at all provided contact points including email.

In signing this form, I absolve Lamar University and its Speech and Hearing Staff from any liability in the exercise of its best clinical decision making and judgments.

_____ _____

Signature (Patient or Guardian) Date

**At My Request**

I hereby grant permission for a release of information to/from doctors, schools or other agencies as specified below.

Agency:_____ Phone:_____

Address:_____

**Signature**:_____Date:_____

Agency:_____ Phone:_____

Address:_____

**Signature**:_____Date:_____

Agency:_____ Phone:_____

Address:_____

**Signature**:_____Date:_____

Agency:_____ Phone:_____

Address:_____

**Signature**:_____Date:_____

# Patient Intake Form

LAMAR UNIVERSITY
Audiology Clinic

| | |
|---|---|
| Title: | Mr. Mrs. Ms. Dr. |
| First Name: | |
| Middle Initial: | |
| Last Name: | |
| Suffix: | |
| Preferred Name: | |
| Address 1: | |
| Address 2: | |
| City: | |
| State/Province: | |
| Zip Code: | |
| Country: | |
| **Marital Status:** | |
| **Employment:** | |

**Insurance: Yes / No**

| | |
|---|---|
| Gender: | |
| Date of Birth: | |
| Preferred Language: | |
| Home Phone: | |
| Work Phone: | |
| Cell: | |
| Other: | |
| E-mail Address: | |
| **Spouses Name:** | |
| School: | |
| Clinic: | Speech / Audio |

**Emergency Contact *OR*** Parent or Guardian(Only if filling out for minor child)

| | |
|---|---|
| Name: | |
| Address 1: | |
| Address 2: | |
| Zip Code: | |
| Relationship to Patient: | |
| Phone Number: | |
| Email: | |

**Physician Information**

| | |
|---|---|
| **Primary Physcian:** | |
| Phone Number: | |
| City: | |
| **Referring Physician:** | |
| Phone Number: | |
| City: | |

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

**Patient/Responsible Party Signature** **Date:**

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LAMAR UNIVERSITY
Department of Speech & Hearing Sciences

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE**

I hereby assign and convey directly to the Lamar University Speech & Hearing Clinic, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.
In the event that a requested service may not be presumed to be a covered benefit, an Advance Notification of Benefits form (ABN) must be filled out and payment is required at the time of services.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare, Medicaid and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.
I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name: _____ Signature: _____ Date: _____

**HIPAA**
By signing below I acknowledge that I have been provided Lamar University Speech & Hearing Clinic's Notice of Privacy Practices and have therefore been advised about how certain health information about me may be used and disclosed by our clinic, and how I may obtain access to and control of this information:

Patient Name: _____ Signature: _____ Date: _____

# LAMAR UNIVERSITY


1. Mamie McFaddin Ward
2. Dishman Art Museum
3. Art
4. University Theatre/KVLU
5. James M. "Jimmy" Simmons Music Building and Rothwell Recital Hall
6. Health & Human Performance Complex A&B
7. Hayes Biology
8. Science Auditorium
9. Theater Arts
10. Social & Behavioral Sciences
11. Geology
12. Archer Building
13. Galloway Business
14. Montagne Center
15. Provost Umphrey Stadium, W.S. "Bud" Leonard Field and Dauphin Athletic Complex
16. Chemistry
17. Ty Terrell Track
18. Sheila Umphrey Recreational Sports Center and McDonald Gym
19. Setzer Student Center
20. Carl Parker Building Undergraduate Advising Center
21. Setzer Center Bookstore
22. Lucas Engineering
23. Wimberly (Admissions)
24. Visitors Parking
25. Plummer (Administration)
26. Communication Building
27. Post Office/Police
28. Family & Consumer Sciences
29. Mary & John Gray Library
30. Engineering Research Center
31. Cherry Engineering
32. Newman Catholic Center
33. Church of Christ Student Center
34. Honors Program
35. Latter Day Saints Student Center
36. Health Center
37. Combs Hall (Cardinal Village III)
38. Wesley Foundation Methodist Center
39. Baptist Student Center
40. Dining Hall
41. Texas Success Initiative/Developmental Studies (former ROTC Bldg.)
42. Maes
43. Gentry Hall (Cardinal Village I)
44. Morris Hall (Cardinal Village II)
45. Education
46. Hydraulics Lab
47. Speech and Hearing
48. Monroe Hall (Cardinal Village V)
49. Campbell Hall (Cardinal Village IV)
50. John Gray Center University Advancement
51. Admissions Visitors Center
52. Brooks-Shivers Hall
53. Human Resources
54. Golf Driving Range
55. Vincent-Beck Stadium
56. Soccer and Softball Complex

College of Fine Arts & Communication
LAMAR UNIVERSITY
Department of Speech & Hearing Sciences

**DEPARTMENT**
OF
**SPEECH & HEARING SCIENCES**

**Lamar University**

**Mission Statement**
The Department of Speech and Hearing Sciences engages and empowers a diverse student population in the acquisition of knowledge and skills through innovative and interactive curriculum design, faculty mentored research, exceptional clinical service delivery, and dedicated outreach to the community. Through these transformative activities the Department of Speech and Hearing Sciences provides interdisciplinary collaboration regionally and globally.

**CONTACT:**

PHONE:
409-880-8338

WEBSITE:
www.lamar.edu/speechandhearing

# SPHS Executive Summary

A. STRATEGIC GOAL: Enhance access to SPHS's educational programs and student services
   a. Objective 1: To strengthen student support
   b. Objective 2: To develop innovative course work and teaching methods

B. STRATEGIC GOAL: Leverage core strengths while elevating the overall quality of education and scholarship
   a. Objective 1: To grow and support top researchers and creative scholars
   b. Objective 2: To ensure equitable workload distribution and salaries
   c. Objective 3: To establish common areas for program development across disciplines

C. STRATEGIC GOAL: Develop a leading-edge environment
   a. Objective 1: To develop forward-looking academic programs, program outcomes, and facilities
   b. Objective 2: To encourage innovative and cutting-edge research and clinical activity
   c. Objective 3: To improve organizational policy and processes workflow to accelerate output and efficiency

D. STRATEGIC GOAL: Enhance data-based systems, metrics, and reporting procedures
   a. Objective 1: To promote use of departmental data to improve enrollment and graduation rate
   b. Objective 2: To promote use of data to improve faculty and staff performance
   c. Objective 3: To use data for assessment of learning outcomes
   d. Objective 4: To use clinic data for assessment of learning outcomes

E. STRATEGIC GOAL: Tell our SPHS departmental story to connect the communities we serve with our mission, accomplishments and aspirations
   a. Objective 1: To tell our story locally
   b. Objective 2: To tell our story nationally and internationally
   c. Objective 3: To engage regional professionals with students/faculty