Kathleen Rose-Le
Speech-Language Pathologist
M.S. CCC-SLP

3531 Jackson Dr.
Holiday, FL 34691
727-99 2 TALK (8255)
Fax: 727-943-9429
Kathleen@TalkReadKnow.com
WWW.TalkReadKnow.com

Please fill out the enclosed forms as completely as possible. The information you give me helps to determine the most effective methods of evaluation. Your background is utilized in setting goals for therapeutic intervention.

Thank you for choosing my practice to serve your needs.

Your communication to ask any questions or give further input is always welcome.

Sincerely yours,

Kathleen Rose-Le
MS CCC-SLP
Speech Language Pathologist
Certified ASHA member
Certified Orton -Gillingams structured language Therapist
Member International Dyslexia Association
State License number SA4698
Four Time Recipient of the ACE Award
American Academy of Private Practice SLPs
Board Certified Cognitive Specialist (ADHD, anxiety, autism, dyslexia)
PROMPT trained

Certified ASHA member
Certified O G Multi-sensory Reading Therapist
Member International Dyslexia Association
State License number SA4698
Three Time Recipient of the ACE Award
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Younger Child Case History Form

Date: _____

Child's Name: _____ D.O.B.___/___/___ Age:_____

Insurance _____ Member #_____

Mother's Name: _____

Address: _____

_____

Home Phone: (____)_____ Work: (_____)_____

Cell: (____)_____ E-mail: _____

Father's Name: _____

Address: _____

_____

Home Phone: (____)_____ Work:(____)_____ Cell:(___)_____

E-mail:_____

Child's Social Security # _____-_____-_____ Medicaid #: _____

(please provide a photo of front and back of all insurance cards. This can be emailed/faxed/texted)

Daycare or school child attends/grade: _____

Child's Allergies: _____

Child's current medications: _____

_____

Referring Physician: _____

Referred by: _____

Reason for today's visit: _____

_____

Please describe any difficulties with this pregnancy and birth: _____

_____

_____

When did your child last see a dentist? _____

When was your child's vision last tested? _____

Results of those tests: _____

Has your child ever had ear infections? No☐ Yes☐

If so, how often? _____

How was it treated? _____

Has your child ever had tubes? If so, when? _____

_____

When was your child's hearing last tested? _____

Results of those tests: _____

Please list current and past medical problems, surgeries, illnesses, diseases, and injuries with dates of occurrences: _____

_____

_____

Has your child ever experienced difficulty with eating/swallowing or had sensitivities to particular foods?

_____

_____

Is your child allergic to any foods or other substances? If so, what?

_____

Does your child display any of these behaviors: (check if observed)

☐ Rocking	☐ Sensitivity to touch	☐ Difficulty with transitions
☐ Jargon	☐ Sensitivity to loud noises	☐ Gags on textured foods
☐ excessive drooling	☐ puts non food items in mouth	☐ picky eater
☐ head banging	☐ clumsy	☐ attention difficulties

Please list the members of your household:

Name Relationship Age

_____

_____

_____

Does anyone in your home have a communication problem? If so, please explain: _____

_____

_____

Does your child have any relatives (outside the home) who have communication problems?

_____

_____

Has your child ever been evaluated or treated for communication impairments in the past? No☐ Yes☐ If so, please explain: _____

_____

Please state age of child's development of the following skills:

Sitting:_____ Walking: _____ Saying words: _____

Saying sentences: _____ Feeding self: _____ Dressing self: _____

Potty Trained: _____ Babbling : _____

Does your child have difficulty with:

Following directions: _____ Describing events or thoughts: _____

Responding to questions: _____ Grammar in speech: _____

Interacting with peers: _____ Attention: _____

Reading: _____

Current modes of communication used by child (i.e. pointing, taking parents' hand to object requested, using words, using sentences): _____

_____

_____

How much of your child's speech do you understand? (25%, 50%, 75% 100%) _____

How much do unfamiliar listeners understand? _____

Goals for this evaluation:_____

_____

_____

_____

_____

_____

_____

Questions:_____

_____

_____

_____

_____

_____

Consent For Release of Information

I, _____ authorize Communication & Learning Solutions to release/obtain
Print parent/guardian name
Information regarding:
Child/client name: _____
Date of birth: _____
City: _____
County: _____
To/from the following institution(s):
Name: _____
Address: _____
_____
Name: _____
Address: _____
_____

Specific Information to be discussed in written and/or verbal communication:

1. OT/PT Evaluations/Progress Reports/Treatment Plans	Release	Obtain
2. SLP Evaluations/Progress Reports/Treatment Plans	Release	Obtain
3. Feeding Evaluations/Progress Reports/Treatment Plans	Release	Obtain
4. Medical Reports/Progress Notes/Treatment Plans	Release	Obtain
5. IFSP/IEP/RCP	Release	Obtain
6. Vision Reports/Progress Notes/Treatment Plans	Release	Obtain
7. Audiological Evaluations/Progress Notes/Treatment Plans	Release	Obtain
8. Other _____	Release	Obtain

The information obtained/released as a result of this form will be used to provide accurate and comprehensive communication among the service provider team.

This consent for disclosure is valid for one (1) year from the date of signature.

I hereby declare that I understand that I have the right to inspect and receive copy of the information disclosed as a result of this form. I understand that I may withdraw consent at any time by written request. I understand that my refusal to consent to disclosure will not result in any other consequence but information will not be disclosed.

_____ _____
Signature of Parent/Guardian Date

Send Information to: Kathleen Rose-Le
Communication & Learning Solutions
3531 Jackson Dr.
Holiday, FL 34691
Phone: (727) 992-8255
Kathleen@talkreadknow.com

PLEASE PRINT AND THEN SIGN FORMS TO COMPLETE YOUR SIGNATURE. SCAN AND EMAIL BACK TO Kathleen@TalkReadKnow.com IF POSSIBLE.

IF NOT BRING THE SIGNED FORM WITH YOU AT YOUR FIRST APPOINTMENT

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Informed Consent for Therapeutic Services

I, _____, authorize Communication & Learning Solutions to enroll,
Print name of parent/guardian

_____ in the following services:
Print name of client/child

- Speech-Language Therapy
- Feeding Therapy
- Reading Therapy

By consenting to these services I declare that I understand, and agree with the following:

1. Orientation regarding services has been explained to me in language that I can understand.
2. My consent to services at Communication & Learning Solutions is voluntary and can be withdrawn at any time.
3. Written reports/documentation regarding the client/child will not released except to those individuals whom have been named in a written, signed release form to accept such correspondence.
4. The client/child's file will be maintained within Communication & Learning Solutions for seven (7) years after discharge.

I have read the above information and fully understand the services in which I hereby consent. I release the agency and their trustees, officers, agents, and employees from any liability to the client any personal injury or property damage suffered by the client as a result of participation in these services. I assume all responsibility and agree to indemnify the agency and hold the agency harmless from and against any and all liability or costs associated with or arising from the client's participation in these services. In case of accident or sickness, I consent to emergency medical care provided by ambulance or hospital personnel.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

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