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DEPARTMENT OF COMMUNICATION DISORDERS
CLINICAL SERVICES INTAKE SCREENING

NAME:_____ M ___ F ___ D.O.B. _____ CA.:_____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

PHONE(S) (INCLUDE AREA CODE): H: _____ W: _____

FAX: _____ CELL PHONE: _____ EMAIL:_____

PARENT/GUARDIAN/CONTACT: _____

RELATIONSHIP TO CLIENT: _____

NAME OF INFORMANT FOR THIS QUESTIONNAIRE: _____

RELATIONSHIP TO CLIENT: _____

ADDRESS (IF DIFFERENT FROM CLIENT): _____

PHONE (IF DIFFERENT): _____

PRIMARY LANGUAGE OF CLIENT: _____ IF CHILD, IS S/HE IN FOSTER CARE? _____

IF YES, PERSON AUTHORIZED TO SIGN FOR CHILD: _____

DATE OF INITIAL INQUIRY CALL: _____ TAKEN BY: _____

APPOINTMENT SCHED. FOR: _____ _____ _____ _____

(day) (date mm/dd/yy) (time) (supervisor)

QUESTIONS TO ASK THE INFORMANT

1. PLEASE INDICATE THE SERVICES THAT CLIENT IS SEEKING.

- SPEECH-LANGUAGE THERAPY (YES/NO) _____ IF YES, THEN SEND PACKET REQUESTING RECENT DIAGNOSTIC INFORMATION.

- SPEECH-LANGUAGE DX (YES/NO) _____ TYPE: (please circle one of the following:)
  VOICE FLUENCY ARTIC LANGUAGE AAC NEURO.(e.g., APHASIA GROUP) OTHER

- AUDIOLOGICAL SERVICES (please check one of the following, if applicable)
  EVALUATION AND PRESCRIPTION _____ REPAIR _____
  EARMOLD _____ ADULT REHAB _____
  HEARING AID ORIENTATION _____ CAPD _____

2. PLEASE DESCRIBE THE COMMUNICATION PROBLEM THAT THE CLIENT IS EXPERIENCING.

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3. **WHAT CAN WE DO TO HELP YOU MOST?**

4. **WERE YOU REFERRED TO US BY SOMEONE? (YES/NO)**

   IF YES, WHO?

   IF NO, HOW DID YOU HEAR ABOUT US?

5. **HAS THE CLIENT RECEIVED ANY HEARING OR SPEECH-LANGUAGE EVALUATIONS OR SERVICES ELSEWHERE? (YES/NO)**

   IF YES, WHERE?

   MAY WE CONTACT THEM? (IF YES, EXPLAIN RELEASE FORM)

6. **IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW BEFORE WE SEE _____?**
   (client's name or appropriate pronoun)

REFERRAL STATUS:

CENTER FOR COMMUNICATION DISORDERS _____

ACCESS NETWORK _____

SOUTHERN CONNECTICUT AUDIOLOGY SERVICES _____