the madison center
pediatric speech & occupational therapy

consent for release form

Patient's Name _____ Date of Birth ___/___/___

Parent/Guardian Name _____

◯ I authorize The Madison Center to release and/or obtain information about the above patient, from the list below.

primary care physician

Name _____ Title _____

Organization _____ Phone _____ Email _____

insurance company

Name _____ Title _____

Organization _____ Phone _____ Email _____

school district/teacher

Name _____ Title _____

Organization _____ Phone _____ Email _____

other

Name _____ Title _____

Organization _____ Phone _____ Email _____

information to be released — *goals/objectives, progress, observations, recommendations.*
I give permission for The Madison Center staff to communicate using electronic mail with the above person(s) and/or myself regarding my child. I understand that this authorization takes effect the day that I sign it.

It expires on ___/___/___ or no more than one year from the date of my signature.

I also understand that I may change this authorization at any time.

Signature of Parent/Legal Guardian _____ Date ___/___/___

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insurance information form

Primary Source of Insurance

Insurance Address

Insurance Phone

Policy Holder | Member ID / Policy Number | Group Number

Secondary Source of Insurance

Insurance Address

Insurance Phone

Policy Holder | Member ID / Policy Number | Group Number

account payment

◯ I request and authorize my insurance company and/or Medical Assistance to make payments of authorized benefits on my behalf to The Madison Center.

I agree that office co-pays and any amount not paid for by my insurance becomes my obligation.

/ /

Signature of Parent/Legal Guardian | Date

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patient information form

Patient's Name | Date of Birth (/ /)

Address | City | State | Zip Code

Parent/Guardian Name

Address

Home Phone | Cell Phone | Work Phone

Email

Parent/Guardian Name

Address

Home Phone | Cell Phone | Work Phone

Email

Primary Care Physician | Primary Care Clinic

Address | City | State | Zip Code

Phone

○ I authorize The Madison Center to release and/or obtain information about the above client, from the listed physician above.

Signature of Parent/Legal Guardian | Date (/ /)

office use only

NPI # | DX Code(s)

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therapy intake form

The Madison Center requests this information for the purpose of completing a thorough evaluation with your child. Depending on your child's abilities, some questions may not be applicable.

general information:

Patient's Name	D.O.B / /	Age	M / F Gender
Person Providing Information		Date	

Is there any known history of the following in the immediate or extended family?

- ◯ Autism/PDD
- ◯ ADHD
- ◯ Learning Disabilities
- ◯ Hearing Loss
- ◯ Stuttering
- ◯ Speech/Language Delays

concern:

1. When did you first have concerns about your child?

2. What made you concerned?

3. What strategies or techniques have you been trying independently?

4. What is your primary concern today?

5. What specific skills would you like your child to achieve in therapy?

pregnancy and birth history:

1. Were there any illnesses, injuries, bleeding, or other complications during your pregnancy?

2. Was your pregnancy full term? If not, please give gestational age.

3. Was labor and delivery normal?

4. What was your method of delivery (vaginal, breech, cesarean)?

   Were forceps or suction used?

5. Was oxygen or respiratory assistance required after birth? Yes / No *(If yes, please explain)*

6. Did you experience any complications with feeding? Yes / No *(If yes, please explain)*

7. How was your child fed as an infant and until what age? Bottle / Breast Age:

8. Please list any concerns regarding your child's eating habits.

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therapy intake form

medical history:

1. Has your child experienced any of the following? *(Please check all that apply)*

◯ Chicken Pox	◯ Seizures	◯ Frequent ear infections or fluid in the ears
◯ Cleft Palate/Lip	◯ Gastroesophageal Reflux	◯ PE Tubes *(If so, when?)*
◯ Vision Problems	◯ Feeding Tube	_____ / / _____

2. Is your child currently taking any medications? *(If yes, please list)*

3. Does your child have any known food allergies? *(If yes, please list)*

4. Has your child's hearing been evaluated recently? *(If yes, when, by whom and what were the results?)*

/ /

Are there any other precautions we should know about that are not described above?

speech/language development:

1. What is your child's primary mode of communication (gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange)?

2. If your child is talking, please indicate at what age your child began to:
   _____ Babble _____ 2-3 word phrases
   _____ First Word _____ Use language as primary mode of communication

3. Please give an estimate of how many words are in your child's vocabulary.

   Receptive (words understood) _____

   Expressive (words spoken) _____

4. How much of your child's speech do you understand?
   ◯ 10% or less ◯ 11-24% ◯ 25-50% ◯ 51-74% ◯ 75-100%

5. How much of your child's speech do others understand?
   ◯ 10% or less ◯ 11-24% ◯ 25-50% ◯ 51-74% ◯ 75-100%

6. Does your child demonstrate frustration when he/she is not understood? Yes / No *(Please explain)*

play and social skills:

1. Does your child engage in eye contact during communication? Yes / No / Sometimes

2. When given a choice, does your child prefer to play alone or with others? Alone / Others

3. How does your child interact with others (shy, aggressive, cooperative, etc.)?

4. Does your child:

Answer questions logically?	Yes / No / Sometimes	Maintain a topic?	Yes / No / Sometimes
Greet people arriving or leaving?	Yes / No / Sometimes	Recall & tell about everyday events?	
Engage in turn taking?	Yes / No / Sometimes		Yes / No / Sometimes
Initiate conversation?	Yes / No / Sometimes	Follow one-step directions?	Yes / No / Sometimes

5. What are some of your child's favorite toys/interests?

education:

1. Does your child attend school? If yes, where and how often?

2. What grade is your child presently in?

3. Please list any services your child receives at school (speech, occupational therapy, physical therapy, tutoring, etc.).

4. May we communicate with the school therapists to collaborate services? Yes / No
(If yes, please list their information on the "Consent for Release" form and provide a copy of your child's most current IEP)

5. Does your child experience any specific challenges in school? *(Please explain)*

Thank you for taking the time to complete this form.