School of Allied Health Clinics

Policy & Procedure Manual

Revised April 2019

The Role, Scope, and Mission of the Louisiana State University Health Sciences Center in New Orleans

The mission of the Louisiana State University Health Sciences Center in New Orleans (LSUHSC-NO) is to provide education, research, and public service through direct patient care and community outreach. LSUHSC-NO comprises the Schools of Allied Health Professions, Dentistry, Graduate Studies, Medicine, Nursing, and Public Health.

LSUHSC-NO educational programs prepare students for careers as health care professionals and scientists. The Health Sciences Center disseminates and advances knowledge through State and national programs of basic and clinical research, resulting in publications, technology transfer, and related economic enhancements to meet the changing needs of the State of Louisiana and the nation.

LSUHSC-NO provides vital public service through direct patient care, including care of indigent and uninsured patients. Health care services are provided through LSUHSC-NO clinics in allied health, dentistry, medicine, nursing, and in numerous affiliated hospitals and clinics throughout Louisiana.

LSUHSC-NO provides referral services, continuing education, and information relevant to the public health of the citizens of Louisiana. In addition, LSUHSC-NO works cooperatively with two Area Health Education Centers (AHECs), whose programs focus on improving the number and distribution of health care providers in underserved rural and urban areas of Louisiana and on supporting existing rural health care providers through continuing education programs.

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SAHP Clinics Policy and Procedure Committee

Erin Dugan (Chair)	Administration / Child & Family Counseling Clinic
	Administration
	Administration
Annette Hurley	Audiology
Rachel Wellons	Physical Therapy
Meher Banajee	Speech-Language Pathology
Joellen Desselles	Occupational Therapy
Meher Banajee	Human Development Center

Glossary of frequently used terms

Caregiver – an individual that accompanies patient to his/her appointment and has responsibility for communicating updated health information between the SAHP clinician and the patient's guardian

Clinician – SAHP licensed practitioner in designated clinical specialty

Guardian – individual granted legal custody and care of another person

Guarantor – individual responsible for the payment of services provided and/or the primary policy holder on the designated insurance plan holder

Referring clinician – non-SAHP licensed independent practitioner

Student – SAHP student supervised by a SAHP licensed clinician

Chapter 1 Clinic Overview

Patient care policies are written policies reviewed annually in a multidisciplinary team approach. The School of Allied Health Professions Clinical Practice Committee assists in the formulation of professional policies. Changes in patient care policies are typically submitted by the professional staff to the Clinical Practice Committee for review and approval and then forwarded to the Dean for approval. Patient care policies govern the quality of patient care, admission and discharge, referral to another agency, patient/family education and the scope of services offered.

The mission of this facility is to provide multidisciplinary outpatient services to achieve diversity of patient objectives that vary in complexity according to each patient's needs. The outpatient services include diagnostic, therapeutic, and restorative services to enable the patients to achieve as much functional, social and occupational independence as is reasonably possible.

The Dean is responsible for the administrative policies on patient care. The Dean will report to the Chancellor on behalf of the patient care Policy Committee regarding patient care policy changes. Representative members of the professional personnel will periodically review this set of policies, proposing updates to reflect changes in services, practice guidelines and government/university regulations.

A written summary of conclusions will be provided. The SAHP Clinical Practice Committee will initiate and oversee policy revision and implementation of any proposed action needed to facilitate changes.

- Speech & Language Disorders
- Articulation Disorders
- Orthopedic
- Physical Therapy Diagnosis
- Management of Neuromusculoskeletal Impairments
- Neurological
- Industrial Rehabilitation
- Sports Medicine
- Central Auditory Processing Disorder
- Auditory & Balance Disorders
- Ear Conditions or Hearing Impairments
- Social, Emotional, Behavioral, Cognitive, & Developmental Impairments
- Educational & Psychological Evaluations
- Clinical Mental Health Counseling

Clinic Locations & Hours of Operation

The School of Allied Health Professions Clinics located at 1900 Gravier Street, floors 7, 8, and 9.

The Physical Therapy Clinic
7th floor, Room 7A11
Monday, Tuesday, Thursday, Friday
7:30 – 4:30pm
Wednesday 7:30-6:00pm

The Audiology Clinic
9th Floor, Room 9A11
Monday – Friday
9:00am – 5:00pm

The Occupational Therapy Clinic
8th Floor, Room 8D3
Monday – Friday

The Speech-Language Pathology Clinic
9th Floor, Room 9A11
8:00am-4:30pm Monday- Thursday

The School of Allied Health Professions Clinics located at 411 S. Prieur Street.

The Child & Family Counseling Clinic
3rd Floor, Room 307
Monday – Thursday
8:00am –5:00pm

The Human Development Center

1.1 Clinician Credentialing and Licensure

1.1.1 Clinician Credentialing

Policy:

All Faculty members seeing patients in the School of Allied Health Clinics must be credentialed prior to scheduling and treating patients.

Procedure:

The credentialing process begins with the submission of:

- A completed Standardized Louisiana Credentialing Application.
- A valid License issued by the appropriate Louisiana state licensing board.
- A current Curriculum Vitae.
- A list of the insurance panels they are presently enrolled in, if coming from an existing medical practice.

Upon receipt of the above information by the Billing Operations Manager, the completed credentialing packet will be sent to each insurance carrier. This process can take 45-90 days commencing with the receipt of the packet by the carrier. Once the Faculty member has been credentialed with an insurance carrier, notification will be sent to the individual and the respective Department Head.

1.1.2 Clinician List by Specialty

One or more of the following professionals provides comprehensive evaluation:

- **Audiologist** (T. Crabtree, M.C.D., CCC-A, Jerald F. James JR. Au.D, CCC-A., A. Hurley, Ph.D., CCC-A, FAA, Megan R. Guidry, Au.D., CCC-A, Megan Majoue, Au.D., CCC-A)
- **Physical Therapist** (R. Wellons, PT, DPT, NCS)
- **Occupational Therapy Clinician** (Mark Blanchard, OTD, LOTR, JoEllen Desselles, MOT, LOTR, Barbara Doucet, Ph.D., LOTR)
- **Licensed Professional Counselor - Supervisor** (E. Dugan, PhD., RPT-S, K. Vaughn PhD., K. Camelford, Ph.D., LPC-S)
- **Licensed Psychologist – (**George Hebert, Ph.D.)
- **Speech-Language Pathologist** (M. Banajee, Ph.D., CCC-SLP, M. Brouillette, M.C.D., CCC-SLP, S. Pancamo, M.C.D.,CCC-SLP, S. Rubin, Ph.D., CCC-SLP, M. Willis, M.C.D., CCC-SLP, B. Wright,M.C.D., CCC-SLP)

1.2 Scope of Services Offered

Physical Therapy Services:

The physical therapy clinic provides evaluation and treatment of impairments to body structure and function, activity limitations, participation restrictions, as well as barriers and hindrances to the environmental. Patients may be see with or without a physician's referral consistent with the Louisiana Physical Therapy Practice Act. Our physical therapists integrate effective treatment with compassionate care in efforts to maximize meaningful functional outcomes for patients and clients. Physical therapy services include, but not limited to:

- Examination, assessment, and treatment in accordance with medical diagnoses and or physical therapy diagnoses
- Therapeutic interventions including, but not limited to exercise, manual therapy, modalities, patient education, family education, and home program
- Referral to physician when medically necessary
- Wellness services

Occupational Therapy Services:

The Louisiana State University Health Sciences Center Occupational Therapy Clinic offers outpatient rehabilitation care for persons with orthopedic injuries, neurological disorders, and chronic conditions. Therapy services are available to clients of all ages, including children and adults. LSUHSC occupational therapists are also certified and trained in specialized services, including Constraint Induced Movement Therapy (CIMT), Lee Silverman Voice Treatment BIG (LSVT BIG), Bioness System retraining, prosthetic training, and neurological and orthopedic rehabilitation. Our knowledgeable clinicians have the expertise to help clients return to DOING the activities they want to do or need to do. Services offered include:

- Constraint Induced Movement Therapy (CIMT)
- Lee Silverman Voice Treatment BIG (LSVT BIG)
- Neurological Rehabilitation
- Orthopedic Rehabilitation

Speech-Language Pathology and Audiology Services:
Provide for a continuum of services including prevention, identification, diagnosis, consultation, and treatment of patient regarding speech, oral and pharyngeal sensory motor function, and hearing and balance. Services include, but are not limited to the following:

- Screening of speech, language, and hearing
- Assessment and diagnosis of articulation, developmental language, fluency, voice disorders, developmental language impairments and hearing, tinnitus, and balance disorders
- Prevention, treatment, restoration, and follow-up services for disorders of speech, language, and disorders of hearing and balance
- Provide consultation and counseling, make referrals when appropriate
- Provide intervention as warranted
- Augmentative and alternative Communication assessment and management
- Hearing aid evaluations, fittings, adjustments, and repairs
- Cochlear implant evaluations, programming and adjustments
- Aural rehabilitation

Child & Family Counseling:
The clinic provides individual, group, and family psychotherapy services to children, adolescents, and their caregivers/guardians. Additionally, the clinic provides training for students/professionals seeking certification to become a Licensed Professional Counselor and/or Registered Play Therapist. Services include, but are not limited to the following:

- Individual Psychotherapy
- Group Psychotherapy
- Individual Play Therapy
- Group Play Therapy
- Activity Therapy
- Family Play Therapy
- Filial Therapy
- Child Parent Relationship Therapy
- Caregiver Consultations
- Professional Consultation
- Supervision
- Professional Seminars
- Professional Speaker Events
- Psychological Assessment & Testing
- Social Skills Groups

1.3 Admittance Criteria

Policy
The characteristics, disabilities, or other qualifications that an individual must possess in order to be treated at this facility.

Procedure:

1. Patients are admitted to the facility without regard to race or ethnicity, gender, gender identity, genetic information, national origin, age, religion, sexual orientation, or disability. Individuals shall not discriminate in the delivery of professional services.
   Patient referral will be screened for appropriateness of services to be provided by the respective clinic and the referral is from a qualified healthcare practitioner as required by law. The physical therapy clinic operates under the Direct Access Law, effective June 6, 2016. In accordance with the new law, Louisiana Physical Therapy Practice Act mandates the following:
   1. A physical therapist possessing a doctorate degree or five years of licensed clinical practice experience may implement physical therapy treatment without a prescription or referral.
   2. A physical therapist treating a patient without a prescription or referral must refer the patient to an appropriate healthcare provider if, after thirty days of physical therapy treatment, the patient has not made measureable or functional improvement.
   3. The new direct access provisions do not change the law as it relates to Workers' Compensation as specified in La. R.S. 23:1142, monetary limits of health care provider approval; La. R.S. 23:1122, Worker's Compensation Medical Examinations; and La. R.S. 23:1203.1, Worker's Compensation Benefits;
   4. No physical therapist shall render a medical diagnosis of disease.

Insurance verification and precertification/authorization will then be performed.

Once authorization has been granted the patient will be scheduled for an initial evaluation and treatment.

The patient must have the ability to benefit and participate with a potential for progress toward goals and treatment/rehabilitation in a predictable period of time.

The patient has demonstrated a deficit in functional, emotional, behavioral, developmental or cognitive ability(ies) that can be appropriately evaluated and/or treated in the respective clinic setting.

The patient must be medically stable to receive treatment in an outpatient setting.

The clinician referral, when required, must be dated and signed, and include treatment orders, precautions, contraindications, if any, and the frequency and duration of treatment, as required per specific disciplines.

The patient must remain under the care of the referring clinician that requires the referring clinician's management during the period services are being furnished.

The patient must have or be able to arrange transportation.

Individuals may not present a security and/or safety risk or have demonstrated disruptive behavior.

The facility is in full compliance with § 504 of the Rehabilitation Act of 1973, Title VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and other Federal legal requirements for nondiscrimination.

1.4 Referral to Another Agency

Policy

To enhance clinician and community relations while maintaining a high standard of care, it is the policy of this facility to refer those individuals whom, for whatever reason, do not meet the parameters of the practice.

Procedure

Prospective and existing patients may be referred to another facility for the following reasons:

1. The discipline/specialty is not provided at the facility
2. The patient's treatment/prescription requires services/equipment not available at this facility. For example, the patient needs special orthotic and functional assistive devices.
3. The clinician does not possess the skill(s) to evaluate the patient, plan the therapy program, and/or carry out the treatment.
4. The patient refuses to follow the referring clinician's orders, precautions, and contraindications, or when the patient refuses to follow the direction and plan of care set up by the SAHP clinician.
5. The patient requests a transfer to another facility.
6. The clinician requests the patient transfer to another facility.
7. The patient becomes medically unstable.
8. The patient is not responding to treatment or further treatment will not result in increased benefit.

Patients will not be transferred on the basis of race or ethnicity, gender, national origin, age, religion, sexual orientation, or disability. Referrals are made to qualified healthcare practitioners that will maximize the patients care as appropriate for their condition(s) and situation.

The professional providing the service has the authority to refer or transfer a patient. In most cases, notification of the referring clinician prior to the transfer is recommended. Documentation of the reason/s for the transfer MUST be recorded in the medical record.

1.5 Clinician's Orders

Policy

Before proceeding with a treatment plan, the SAHP clinician must first obtain an appropriately licensed clinician to treat in Occupational Therapy and Physical Therapy, and where applicable, for Speech-

Language Pathology, Audiology, and Child & Family Counseling . The SAHP clinician is responsible and is accountable under the law to direct and coordinate the care of the patient as appropriate.

Procedure

1. A physician's order is required in the following instances for
   a. Occupational Therapyi. Before a patient can be treated
      ii. Whenever the SAHP clinician adds modalities
      iii. To certify the need for continued therapy

   b. Audiology
      i. Medicare patients
      ii. Hearing aids for patients under 18
      iii. Medicaid patients

   c. Physical Therapy Provider Referral

   When treating patients without a referral, if they have not shown "measurable or functional improvement" in 30 days of PT treatment, the patient must be referred to an appropriate healthcare provider.

   d. Speech-Language Pathology
      i. Medicare patients
      ii. Medicaid patients
      iii. Voice patients

   e. Child & Family Counseling
      i. Insurance related patients needing authorization

2. A clinician is allowed to accept an order from a nurse and/or physician's assistant with the co-signature of the referring physician/dentist.

3. The clinician is required to comply with the order as written unless doing so would cause harm to the patient or would be contrary to the Clinician's Professional Standards of practice or respective discipline's standard procedure.

4. Every thirty (30) days, the clinician must re-certify the need for continuing therapy for Medicare patients and, as stated, on prescriptions for other patients.

5. The medical/psychological/psychiatric diagnosis needs to be made by the physician/psychologist/psychiatrist. If the diagnosis is included in the order that the physician signs, this will validate the diagnosis.

6. All entries made in the SAHP clinical record must be signed by a SAHP licensed clinician. In the instance where there is a student or intern providing services, the licensed clinician must sign off as the supervisor in such cases.

Physician Verbal, Phone and Fax Orders

Policy

Verbal, phone, and fax orders are acceptable, but must be supported by documentation which shows the date, time, exact contents of the order, the physician's name, the signature and title of the professional receiving the order. The documentation must be included in the patient's clinical record.

Procedure

1. A licensed clinician is the only authorized staff member to take verbal and phone orders. Verbal orders should be immediately communicated to the treating clinician in detail and documented in the patient's file.
2. The standard format is as follows:
    a. Verbal and phone orders should be recorded on a facility prescription pad and marked "verbal order" in the clinician's signature area
    b. Date/Time/Exact Order
        i. Verbal Order Clinician name/Clinician signature, Discipline (i.e. Physical Therapy) Example: 8/14/08, 2:15pm, Verbal Order Jane Doe, MD/John Doe, PT, Physical Therapy
    c. Name of clinician giving the order
    d. Name of the patient on the page the verbal orders are written
    e. Complete transcription of order
    f. Written counter signature by the clinician should follow within seven days of a verbal or phone order and will be placed in the patient's clinical record. The administrative staff in the clinic is responsible for following up on this paperwork.
3. The verbal order will remain in the clinical record of the patient.

1.6 Discharge Criteria

Policy

The characteristics or other qualifications that an individual must possess in order to be discharged from this facility.

Procedure

1. Patient has achieved long term goals of treatment plan.
2. Patient has reached a "plateau" and is maintaining status rather than showing on-going improvement towards goals.

3. The patient becomes medically unstable resulting in inability to tolerate services.
4. The referring clinician discontinues therapy services.
5. The patient is independent in functional activities.
6. The patient needs a higher level of care, such as admission to a hospital, long-term care facility or inpatient rehabilitation unit.
7. Treatment is no longer deemed reasonable and necessary.
8. The patient discharges self from care.

9. The patient is no longer able to participate in the treatment program because of financial or insurance considerations.
10. The patient transfers to another facility for services.
11. The patient no longer returns for prescribed treatment and/or attendance is irregular.
12. Patient is unable to arrange transportation.
13. The patient refuses to follow the plan of care and treatment directions.
14. The patient refuses to follow clinician's orders, precautions, and/or contraindications.
15. The patient is abusive or dangerous to the staff, students, or other patients.
16. The patient will not be discharged on the basis of race or ethnicity, gender, national origin, age, religion, sexual orientation, or disability.

1.7 Education of Patient and Family

Policy

It is essential for the patient and the patient's family members to understand the total treatment/rehabilitation process in order for the patient to benefit from progress and growth.

Procedure

The integral component necessary to insure cooperation from the patient and his/her family is education of all involved through explanations of the total scope of the rehabilitation program, as applicable. The educational explanations must cover all aspects and include:

1. The patient or patient's caregiver(s)/guardian(s) will be educated in admission and discharge criteria, and the type of treatments including length, duration, frequency, and expected outcomes.
2. The patient or patient's caregiver(s)/guardian(s) will be educated in expected outcomes of the treatment provided including realistic goals and milestones, and should demonstrate an understanding of these goals.
3. The patient or patient's caregiver(s)/guardian(s) will be instructed regarding the consequences of missed appointments and absences from the treatment program and the advantages of regular attendance.
4. The patient or patient's caregiver(s)/guardian(s) will be instructed in a home program accompanied by written handouts as available.
5. As appropriate, the patient or patient's caregiver(s)/guardian(s) will be informed of the diagnosis through patient education brochures, handouts, videos, drawings, books, etc.
6. The clinician should advise patient or patient's caregiver(s)/guardian(s) on the type and frequency of communication with referring clinician.

Whenever possible, the patient's caregiver(s)/guardian(s) will be included in the process. Repetition of explanation and demonstrations of treatment are the most effective method to insure that the patient

and the patient's caregiver(s)/guardian(s) will understand and retain all important aspects of the material that have been communicated.

The Child & Family Counseling Clinic requires the legal guardian(s) to sign the child's/family's informed consent and both the legal guardian(s) as well as the clinician to sign the child's/family's treatment plan prior to beginning services.

1.8 Emergency Management of a Patient, Visitor, and/or Employee

Policy

To provide emergency care or take action in a situation occurs that could endanger any patient, visitor, and/or employee during the time he/she is on the premises. A medical crisis shall be defined as: the onset of a new symptom; the onset of a new sign, such as a significant change in cardiac rhythm and/or rate; or an injury sustained while on the premises. An unexpected occurrence or accident unrelated to the person's health or underlying condition that may endanger the individual and/or others including, but limited to, fire, loss of electrical power, facility lockdown, or external disaster.

Procedure – Medical Event

1. The staff member will alert the Administrator or supervisor that an emergency action needs to be taken.
2. The clinician, a licensed faculty member or Department Head will evaluate the situation. The referring clinician will be notified as soon as possible.
3. If the determination is made that the patient's crisis must receive immediate attention, then the appropriate telephone number is called to bring an ambulance/rescue unit to the facility for transport of the individual to the nearest emergency room.
4. The individual should be made as comfortable as possible, with the goal of reducing further negative consequences.
5. Should the situation become life-threatening or critical whereby intervention is deemed necessary, a certified CPR clinician or staff should administer appropriate care.
6. Possible scenarios:
    a. A patient is not breathing. Establish an airway if the person has stopped breathing. Position yourself at the person's side. Place one hand on his/her forehead and the other hand under his/her neck. With your hands in position, gently push down on the forehead and lift up the neck. If you suspect a spinal injury, use and alternate method that does not involve hyperextension of the neck. If still not breathing, clear airway and begin artificial ventilation.
    b. No carotid pulse, start CPR efforts without delay.
    c. Cardiac/Respiratory Problems. If the patient is alert and responding, keep the patient in a sitting position by the use of pillows or elevating the head of the treatment table. Regularly monitor the pulse and blood pressure. A staff member must remain with the individual, do not rely on a member of the family.

d. Injury sustained on the premises.

   i. *Bleeding*

      1. Profuse bleeding – control bleeding by direct pressure with a clean compress on the wound and elevation of the injured body part, if possible.
      2. Non life-threatening bleeding - wound should have a clean compress applied to decrease the blood flow. When the flow of blood has ceased, the patient should be directed to go to an emergency room/urgent care facility to be evaluated for further care (stitches, tetanus shot, wound cleansing and dressing).

   ii. Falls

      1. Any person who falls should be treated as if a bone has been broken. The person should remain where he/she fell until a professional can evaluate the situation. The person should be encouraged to seek a medical evaluation of the affected area.
      2. If the person must be moved, immobilize the extremity before moving the person. Do not attempt to reduce or straighten a dislocation.

   iii. Possible stroke, numbness or impaired movement/speech

      1. Have person stop what he/she is doing and rest in a comfortable position. Do not let the person eat or take medication. Call EMS for help.

7. It is the responsibility of the professional in charge of providing the clinical services to document the crisis by completing an incident report [DA 2000 for employees and DA 3000 for patients and visitors]. If the individual is a patient the report should also be filed in the patient's clinical record, including the evaluation, care given, and recommendations given to the patient. Each clinic must retain copies of all incident reports and maintain annual tracking form. All forms need to be signed by the clinic supervisor. A copy of the report must be sent to the Dean's office.
8. Maintain effective communications with family and other visitors while person is being cared for in a treatment area, as they are being required to wait in the reception area.
9. The treating clinician will contact the person/s listed on the patient's or employee's emergency contact form.
10. The professional staff should provide all necessary information, including a verbal report, to the emergency personnel and the referring clinician. If the person is subsequently admitted to a hospital, a copy of the clinical report may be transferred after the appropriate release of records authorization form is signed.
11. All emergency information should be recorded in the patient's clinical record including the date and time of the incident, the type of care rendered, personnel involved, and the event that precipitated the need for such care.
12. Only personnel who are certified in cardiopulmonary resuscitation should administer appropriate care.

Procedure - Unusual Event

1. The staff member will alert the Administrator or Clinic Supervisor that an unexpected event has occurred and action needs to be taken.
2. Administrator or Clinic Supervisor will evaluate the situation to determine if action needs to be taken.
3. Should the situation require action to be taken, Administrator or Clinic Supervisor will follow the appropriate Safety and Facilities emergency procedures. http://www.is.lsuhsc.edu/safety/default.aspx **Important phone numbers**, refer to **Page 34**.

1.9 Signature Identification List

Policy

Entries in a patient medical record may only be made by authorized individuals.

The following health care professionals are permitted to make entries in the patient's clinical record:

- Licensed audiologists and students in the Doctor of Audiology program
- Licensed occupational therapy clinicians and students in the Master of Occupational Therapy program.
- Licensed physical therapy clinicians and students in the Doctor of Physical Therapy program.
- Licensed professional counselor or registered play therapists and students in the Master of Rehabilitation Counseling program and interns in the Child & Family Counseling Clinic.
- Licensed speech-language pathologists and students in the Master of Communication Disorders program.

Every entry that is made into the clinical record should be signed. All records will be signed with a legal signature (legal first name or initial and last name). Nicknames are not allowed. Professional initials follow the last name indicating the professional's credentials.

The signature of a student is always followed by a slash and then the signature of the supervising clinician. When an assistant makes an entry, a co-signature from the supervising clinician will be required.

1.10 Patient Confidentiality

The School of Allied Health Professions adheres to the Health Information Portability and Accountability Act (HIPAA) and the Code of Ethics for each clinical specialty within the school. All information gathered on a patient is considered confidential.

- Information obtained from an evaluation and/or treatment session cannot be released to individuals other than the patient without authorization of the patient or his/her guardian(s)/designated representative except for payment, treatment or operational activities.

The Authorization of Medical Record Information form must be signed and include the names of individuals to whom we may send information.

- Prior to taking pictures, video or audio recordings for teaching and supervision purposes, the Consent to Photography, Videotape, Audiotape form must be completed and signed by the patient or his/her designee(s)/guardian(s)/caregiver(s).
- Patient confidentiality must be observed at all times. Patient histories, diagnoses, treatment plan and prognosis are not to be discussed outside the diagnostic or management room in which you are working. Consultation with a supervisor, student or colleague should be held in a private room and not in the hallway or public area. Discussion should never take place in public areas or social situations.
- Working folders for clients and treatment room schedules should identify the patient by initials or patient number, not by name.
- Encryption of computer disks. All computers with stored patient information must be encrypted using software deemed appropriate by LSUHSC Office of Compliance Programs and SAHP IT staff. Electronic patient information should not be e-mailed to others or stored on portable disk drives or thumb drives.
- The Physical Therapy Clinic uses Web PT which stores medical records electronically. The software application is password protected, encrypted and HIPAA compliant. Access to patient records is limited to the clinicians and the billing office manager.

Chapter 2 Pre-visit Procedures

2.1 Patient Scheduling

2.1.1 Phone requests

Using the New Patient Appointment form (the one used in PT & CFCC clinics), primary patient complaint and demographic information is collected from the caller to include reason for appointment, patient full name, contact phone number, address, date of birth, type of insurance, guarantor name, guarantor date of birth and guarantor social security number.

Patient or the patient's caregiver/guardian is notified that intake forms are available on the Clinic webpage for printing and should be completed prior to the 1st visit.

Based on clinical availability and patient's preference an appointment is set-up in the clinic schedule. Patients or patient's caregiver/guardian is told to arrive 15 minutes prior to appointment time to complete paperwork. Information on clinic location, parking and driving directions are provided.

Patients to be seen by Speech-Language Pathologists will be sent a case history form to be completed and returned prior to the first visit. That will allow time for review of the history information to determine who would be the best person to see the patient based on areas of expertise. The patient or patient's caregiver(s)/guardian(s) will be instructed to arrive for the appointment at least 15 minutes early to complete registration paperwork Information on clinic location, parking, and driving directions are provided.

Patients to be seen by the Child & Family Counseling Clinic will be sent a New Patient Contact Form via email, fax and/or U. S. Mail at the request of the caregiver. Upon receipt of the New Patient Contact Form, the supervising clinician will review and decide if the case is an appropriate fit for the Clinic within 24 hours. This will allow time for review of the presenting information and reason for referral to determine who would be the best person to see the patient based on areas of expertise. Once the supervising clinician approves the referral, those patients who are using insurance will be sent to the Billing Office to review and confirm insurance coverage and benefits within 24 hours. Upon receipt, the administrative coordinator will contact the responsible party to review coverage. Upon review a Biopsychosocial History questionnaire will be sent along with Intake paperwork (including consent, authorization, contact, and HIPAA forms) to be completed and brought to the first visit. The patient or

patient's caregiver(s)/guardian(s) will be instructed to arrive for the appointment at least 15 minutes early to complete registration paperwork, information on clinic location, parking, and driving directions are provided. Should the caregiver(s)/guardian(s) not have all paperwork complete upon arrival, the respective clinician reserves the right to reschedule the initial intake session.

Patients to be seen by Audiologists schedule appointments at the time of contact. The caller provides name, age, contact information and type of appointment needed and the clinic administrative assistant or faculty member schedules the patient for an appointment. Patient or patient's caregiver/guardian is told to arrive 15 minutes prior to the appointment time to complete paperwork. Information on clinic location, parking, and driving directions are provided.

2.1.2 Referral or Screened Patient

Patients or the patient's caregiver/guardian is contacted to arrange appointment based on clinician availability and patient's preference. Any additional information needed to complete the New Patient Appointment form is collected from the patient or guardian. Information on clinic location, parking and driving directions are provided.

2.1.3 Walk-ins

Clinician availability is determined based on the individual's clinical complaint and availability of a clinician. When a clinician is available to evaluate the individual, the appointment is entered in the clinic's appointment calendar. The patient or patient's caregiver/guardian is given the new patient forms to complete and returned to the front desk. In some situations the patient can be evaluated but not treated until a referral is obtained from an appropriately licensed clinician.

The Audiology Clinic accepts, walk in patients immediately based on audiologist availability. If the problem is with an amplifications device a walk in may leave the device with contact information and the audiologist will contact the patient once the device has been inspected and evaluated. Walk in patients are also seen for sales of amplification supplies. Audiology patients with hearing equipment problems may be able to leave the device with relevant information on the problem/s and contact information. Patients needing to purchase equipment resale items do not need an appointment.

2.2 Patient eligibility

2.2.1 Insurance coverage is verified using information provided by the patient or patient's guarantor. Insurance benefits must be verified by accessing the insurance company website or by telephone. Be prepared to provide a combination of the guarantor's insurance policy number, group number, patient name and date of birth; and guarantor name and date of birth.

2.2.2 Coverage for services to be provided must also be verified. Make sure that the individual's health insurance plan covers the type of service to be provided. Many plans provide coverage for patients under 18 years of age differently than for adults. Some plans will not provide any coverage for specific services such as hearing aids or other durable medical equipment.

Should a patient's coverage be terminated, each clinic reserves the right to determine whether a referral will be given to the patient and/or patient's responsible party/caregiver/guardian and/or continuance of care despite lack of coverage. The treating clinician and clinic director will work with the patient or patient's responsible party/caregiver/guarantor on a payment plan or a referral to qualified provider.

2.3 Referral/Authorization

2.3.1 Prior to providing services, the patient's insurance plan must be checked to determine whether a referral or authorization number must be obtained in order for the clinician's services to be reimbursed by the insurance carrier. This is especially important for commercial insurance carriers that have multiple health plan options.

2.3.2 When an authorization number is required, it must also be determined whether the authorization number covers a specific period of time and/or number of visits.

2.4 Appointment reminder

Each patient or patient's caregiver/guardian must be contacted by email or phone the work day prior to the patient visit at the preferred phone number. Monday appointments will be confirmed on the preceding Fridays. The employee placing the call should ask for the patient or guardian by name and only provide appointment information to that individual. If the patient or guardian cannot come to the phone or the call is not answered a message should be left asking her/him to return the call. Do not provide any health information in the message. The Child and Family Counseling Clinic will send a voice mail, or text to the patient number provided using Tavoca automated messaging systems.

Example: "Good [morning/afternoon], may I speak to Ms./Mr. [patient or patient's caregiver/guardian last name]".

When speaking to the patient or patient's caregiver/guardian the employee should introduce himself/herself = "This is [employee first name] at LSUHSC [clinic name]. I am calling to remind you of your appointment [day and date] at [time]. Will you be able to come to the appointment? "

If the person indicates they will come to the appointment thank him/her, ask if directions or needed and tell them we look forward to seeing them on [day, date].

If the person cannot come to the phone or the call is not answered: "Please call [employee name] at LSUHSC [clinic name] at (504) 568-[extension].

2.5 Appointment Cancellation

2.5.1 When patient cancels appointment less than 12 hours prior to appointment, remind the patient/guarantor to provide at 24 hour notice in the future so that appointment slot can be used by another patient. Indicate the patient cancelled using the scheduling module code or "CC" next to the patients name on the appointment calendar.

The Child and Family Counseling Clinic reminds the patient's caregiver(s)/guarantor(s) a "one time" No- Show without charge. After that "one time" is used by the patient's caregiver(s)/guarantor(s), a missed session fee in the amount of $100 is charged privately to the patient's caregiver(s)/guarantor(s). This policy is provided to patient's caregiver(s)/guarantor(s) at the initial intake and a form acknowledging their signature is required.

The Physical Therapy Clinic does not reschedule patients that cancel more than 1 appointment in a row. If the patient cannot be contacted upon repeated attempts or continues to cancel, a determination is made by the treating physical therapist clinician when to discharge the patient.

The Audiology and Speech-Language Pathology Clinics document and log cancellations when it is a returning patient. Frequent cancellations are handled on an individual patient basis taking into consideration the reason/s for the cancellations.

2.5.2 When the patient appointment is cancelled by the referring provider, agency or the patient on the advice of the referring provider or agency indicate the cancellation with "Cx" in the appointment book or using the appropriate code in the scheduling module.

Notify the treating clinician immediately and place a note in the front of the patient medical record indicating that the patient's therapy has been cancelled by the referral source. The patient chart is placed in the clinician's in-box.

2.6 Patient No-Show

The patient/guarantor should be contacted by phone to attempt to reschedule the appointment and determine reason for the no show. If the clinic employee is unable to contact patient/guarantor in person, leave a message providing only your first name, the name of the clinic and the phone number. If she/he is unable to leave message, he/she must make a second attempt to contact the patient/guarantor. All attempts to contact patient/guarantor must be documented in the appointment module or book.

The Child and Family Counseling Clinic reminds the patient's caregiver(s)/guarantor(s) a "one-time" No-Show without charge. After that "one-time" is used by the patient's caregiver(s)/guarantor(s), a missed session fee in the amount of $100 is charged privately to the patient's caregiver(s)/guarantor(s). This policy is provided to patient's caregiver(s)/guarantor(s) at the initial intake and a form acknowledging their signature is required. (Refer to appointment cancellation on page 24.)

The Audiology Clinic does not provide further appointments to patients that no show for 2 appointments without the permission of the audiologist.

The Speech-Language Pathology Clinic will not reschedule a diagnostic patient with three consecutive no-shows/cancellations. Therapy patients with three no-shows are dropped will not be rescheduled.

The Occupational Therapy and Physical Therapy Clinics will handle patients that cancel and/or no-show for consecutive visits on an individual basis. If a patient cancels or no-shows for an evaluation visit one attempt will be made to reschedule the appointment. Patient will not be rescheduled if they cancel or no-show the second appointment.

For individual clinic forms and procedures, in addition to the information above, see Appendix A.

Chapter 3 Patient Visit

3.1 Check-in

3.1.1 Initial Visit

- Patient or patient's caregiver/guardian is greeted by the front desk employee, asked to sign the sign-in sheet and marked as arrived on the clinic schedule.
- Sign-in sheets are copied and compared to all fee schedule sheets within 24-hours to promote accuracy of charge entry and patient sign-in.
- Patient payment is collected.
- A clipboard with forms that need to be completed is given to the patient or patient's caregiver/guardian with instructions to complete the paperwork and return them once completed along with the patient's picture ID, preferably a driver's license, and insurance card/s.
- Copies are made of the picture ID and insurance card/s and returned to patient/patient's caregiver/guardian.
- Forms are checked for completion and missing information is obtained from the patient or patient's caregiver/guardian.
- The patient or the patient's caregiver/guardian is told that they can have a seat and the clinician will be with them shortly.
- Notify clinician that the patient or patient's caregiver/guardian has arrived and is ready to be seen.

3.1.2 Return visit/Therapy session

- Patient chart is checked to make sure authorization/referral information is current.
- Patient payment is collected on any outstanding patient account balance.
- Patient or patient's caregiver/guardian is told that they can be seated and the clinician will be with them shortly.
- Notify clinician that patient or the patient's caregiver/guardian has arrived and is ready to be seen.

3.2 Registration

New patient registration forms and patient updates must be faxed to the billing company to be entered into the patient billing system. In some situations a minor change can be made in the billing system with approval by the billing operations manager. Patient information is usually entered within 1-2 business days by the billing company.

3.3 Consent for Care

Before treatment can be initiated, authorization must be obtained from the patient, or in the case of a minor or dependent adult, the caregiver/parent or legal guardian of the person. It is the duty of the staff to disclose all relevant information concerning the proposed course of treatment including any risks.

Consent will be obtained in writing. If an adult is unable to give consent because of an inability to understand the nature, purpose, and/or risks involved, consent must be obtained from a legally appointed guardian. If the adult patient is temporarily unable to give consent, consent may be obtained from another person, if that person was authorized previously to give such consent by the patient undergoing treatment.

3.4 Establishment of a Plan of Care

Overview

Documentation is the linkage between the professional who provides care for the patient, the database internally within the facility for quality assurance and assessing the effectiveness of treatment, and a legal record that can be used in a court of law.

Documentation should be clear, concise, and specific. Any extraneous information that does not assist in making a coverage determination should be eliminated.

Policy

An initial assessment of the patient is performed by the treating clinician to determine and establish a plan of care that is based on, the results of the assessment, and the specific needs of the patient. All documentation in the clinical record will be legible and written black or blue in ink.

Procedure

1. The patient or patient's caregiver(s)/guardian(s) prior to seeing the clinician for the first time may be asked to complete a medical history form. The clinician may need to know the following information about the patient:
    a. Significant past history
    b. Date of onset and exacerbation of injury or complaint/concern
    c. Current medical findings
    d. Diagnosis, degree and type of dysfunction(s)/impairment(s)for which treatment is being considered
    e. Rehabilitation potential and extent patient is aware of prognosis
    f. Brief summary of previous treatment for the condition, if applicable
    g. Ambulatory status
    h. Pertinent social information
    i. Contraindications to treatment
    j. Medications patient is taking and any allergies

The initial clinician prescription for therapy must be renewed every 30 to 90 days as required by the payer source "or as dictated by the treating professional's State Practice Act" and will include:

    k. Name, address, and age of patient, and/or date of birth
    l. Diagnosis/es and date of onset or date of surgery
    m. May include the patient's chief complaint
    n. Reason for referral
    o. Type of treatment and frequency, or "Evaluate and treat" order
    p. Contraindications, precautions and/or special instructions
    q. Signature of referring clinician and date

2. An initial evaluation is required for all patients receiving services at this facility prior to treatment. The licensed clinician performs and documents an initial evaluation and interprets the results to determine appropriate care for the patient.
    a. Identifying information:
        i. Patient name
        ii. Date of evaluation
        iii. Patient's date of birth

iv. Insurance name and policy numbers
v. Location where services are being provided (facility)
vi. Referring clinician's name (if available)

b. Evaluation/Assessment
    i. Date of evaluation
    ii. Description of patient's complaint/s, concern/s
    iii. Description of pertinent background information and medical information
    iv. Description of current functional level
    v. Description of functional level prior to onset of the current illness or injury, including past treatments and results, if applicable
    vi. Subjective observations
    vii. Patient's attitude toward treatment/rehabilitation
    viii. Existence of any social/psychological/vocational problems affecting treatment/rehabilitation
    ix. Any possible need for referral to outside agency

c. Plan of treatment
    i. Area/s to be treated
    ii. Modalities to be utilized
    iii. Frequency of visits
    iv. Estimated duration of plan
    v. Statement of functional goal for each problem area
    vi. Patient and family education
    vii. Precautions and special instructions

d. Analysis of assessment
    i. This involves the professional judgment of the clinician in identifying the patient's problems and setting goals and priorities.
    ii. The short-term goals are the interim steps along the way to achieving the long-term goals (if applicable).
    iii. Long-term goals are the expected outcome that will be reached to meet the specific needs and problems of the patient (if applicable).

iv. Goals must be patient oriented, measurable, attainable, realistic and representative of the patient's capabilities.
v. Along with the goals, the clinician indicates the target date of expected completion.
vi. Changes in the plan of treatment must be documented. The referring clinician will be advised of changes and will acknowledge these changes by providing a signature.

Note: The Child & Family Counseling Clinic must have the patient's caregiver(s)/guardian(s) sign off on the treatment plan prior to the initiation of services.

e. Summary (if applicable)
    i. The clinician will collaborate with the facility's other professional services in developing the patient's total plan of care.
    ii. The patient or patient's caregiver(s)/guardian(s) will participate in the proposed plan of care.
    iii. The referring clinician and the Allied Health Professional will sign the evaluation/plan care for Medicare.
    iv. The plan of care is based on the diagnosis, the clinician's evaluation, and the clinician's treatment objectives.

3. Re-evaluation (if applicable)
    a. After the first four weeks or as indicated, the clinician will complete a reassessment of the patient's response to the initial treatment to determine if a change is warranted or if the treatment plan should continue. If there is a significant change in the patient's condition, whether it is progressive or regressive, then a re-evaluation may be performed sooner.
    b. Interim assessments should include:
        i. A statement of progress, regression or plateau
        ii. Reasons for no treatment days
        iii. Identifying the level of patient participation, motivation, mental status, and response to treatment

iv. Justification for continued care. Documentation of evidence of either a problem necessitating active treatment, or observed or expected improvement in functional ability.
v. Notification to referring clinician of need for re-certification every thirty (30) days "or as indicated by the treating therapist's State Practice Act, Medicaid or Medicare guidelines."
vi. A copy of the re-evaluation will be sent to the referring clinician.
vii. Services will not be suspended while awaiting receipt of clinician's remarks.

4. Progress Notes
    a. A periodic evaluation of the patient's response to treatment is required, so it is necessary to write a note/log once every session for Audiology, Physical Therapy, and Speech-Language Pathology and once a week for Occupational Therapy.
    b. The method and measures used to demonstrate progress remain consistent during the treatment program. If the method used to demonstrate progress is changed, the reason for the change must be documented.
    c. The progress note will document:
        i. Date service provided
        ii. Progress towards goals defined in patient plan of care
        iii. Objective evaluation of patient's progress and response to treatment
        iv. Current tests and measurements
        v. Subjective impressions and observations
        vi. Changes in medical status if appropriate
        vii. New findings
        viii. Changes in the treatment plan with rationale for change
        ix. Signature of clinician or assistant (with co-signature of clinician)
5. Discharge Summary
    a. Each professional involved in the care of the patient should attempt to anticipate the discontinuance of treatment with eventual discharge.
    b. The discharge summary should include:
        i. A comparative review of patient's status relative to initial evaluation
        ii. Any instruction given for home treatment

iii. Indication of which goals have been achieved, which have not been achieved and why
iv. Assistive devices the patient is or will be using
v. Date and reason for discharge
vi. Referral to community agencies for assistance with other needs.
vii. The number of times the patient was seen in therapy
viii. Any instances of patient skipping or cancelling treatment sessions
ix. Where patient is being discharged
x. Recommendations for follow-up treatment or care to patient
xi. Signature of clinician and date

6. The clinical record will also include
    a. Special tests and measurements
    b. Consultation reports
    c. Correspondence with clinician/other professionals
    d. Treatment record
        i. Treatment and procedures used
        ii. All treatments signed and dated
        iii. Any other service statistics

3.5 Encounter

The licensed clinician is responsible for all clinical notes related to the patient encounter. Patient services should be documented on the clinic billing sheet. The sheet should include date of service, patient name, procedure code/s, diagnosis code/s, modifiers (if applicable), patient account number or date of birth.

Patient chart notes should be completed and chart placed back in the designated secure storage location and filed correctly.

3.6 Check-out

If appropriate, the patient or the patient's caregiver(s)/guardian(s) should be scheduled for his/her next clinic appointment/s. Therapy patients with more than one session per week may need to be schedule for several visits to ensure that they have appointments that fit their schedule. The patient or patient's

caregiver(s)/guardian(s) may receive instructions exercises that can be done on their own between therapy sessions.

Patient/patient's caregiver/guardian should be asked if they need a parking ticket validation.

Patients or patient's caregiver(s)/guarantor(s) should remit payments if they have not done so at check-in due to the need to purchase durable medical equipment or supplies.

Treatment area (tables, chairs, exam table, etc.) must be wiped down with disinfectant wipe after patient has left and before the next patient is placed in the room/treatment area. Soiled linen should be removed and replaced with clean linens. Dirty linen must be put in the dirty linen hamper.

Clinical instruments and equipment should be returned to the appropriate storage location.

3.7 Termination of a visit

If the clinician or caregiver determines that the patient is unable to attend or continue services due to physical, medical or other reasons related to his/her overall wellbeing, the visit may be terminated without interruption of services and the appointment will be scheduled.

3.8 Patient Survey

Periodically each clinic distributes a Patient Satisfaction Survey form to patients at the time of the patient visit. The purpose of the survey is to gather patient feedback on the services the patient has received by responding to set of standard questions and provide comments regarding the clinic. Completed surveys are put in a locked box in the clinic and retrieved by the Billing Operations manager for tabulation and reporting. Participation by the patients is voluntary and responses remain anonymous. All patients who are being discharged/terminating will be provided a survey during their last session.

3.9 Patient Complaint

Should a patient be dissatisfied with services provided the complaint should first be addressed with the primary clinician treating the patient. If after discussion the matter is not resolved to the patient's satisfaction, the clinic director should be notified. Should a complaint not be resolved by the clinic director the patient's complaint should be forwarded to the Associate Dean for Academic Affairs in writing describing the reason/s for the compliant and proposed resolution by the clinician and clinic director. If the Associate Dean is unable to resolve the complaint, the Dean will review the complaint and render a written decision. The Dean's decision will be sent to the patient, primary clinician, clinic director and Associate Dean.

Chapter 4 Post Visit Procedures

4.1 Charge capture/posting

The SAHP clinics utilize a Master Fee Schedule. Fees for services rendered and billed to the patient's insurance carrier and the patient are based on the Master Fee Schedule. The Master Fee Schedule is reviewed annually by the Clinic Providers, Department Heads, Billing Operations Manager and the Assistant to the Dean for Clinical Affairs.

Each clinician is responsible for entering procedural codes and signatures for each patient serviced within 24-hours of the patient encounter and submit the billing sheet to the clinic administrator for charge entry. Each Clinic administrative employee is responsible for batching, proofing and entering patient charges within 7 business days of patient encounter. Billing sheets with missing procedure and diagnosis information should be returned to the clinician with a note indicating the exception/s. Missing demographic, insurance and appointment information should be found and written on the form by the clinic administrative employee.
Educational and psychological evaluations charges are not entered until the report is written and completed.
Hearing aid charges are held in suspense until the patient has accepted the hearing aid device and the hearing aid vendor invoice has been approved for payment.

Clinic patient sign-in sheets are also compared to the patient fee sheet to promote accuracy of billing. The clinic administrator will compare sign-in sheets with fee sheets within 24-hours.

4.2 Cash Management

Payments received from a patient or patient's caregiver/guarantor in the clinic must be recorded in the receipt book assigned to the clinic by the Billing Operations Manager. [See Receipt Example, Appendix F]. All required fields on the receipt must be completed. Credit card machines must be balanced at the end of each work week by the clinic administrative employee. Payment batch summary sheet is completed and submitted to LSUHSC Accounting Services within 1 week of receipt of payment.

Hearing aid payments are sent for deposit to LSUHSC accounting and held in suspense until the hearing aid has been accepted by the patient and the hearing aid vendor invoice is approved for payment.

4.3 Payment posting

Patient payments are posted to the billing system by the Billing Office Manager within 7 business days of payment receipt. Copies of contract payment information received in the SAHP bank lockbox is forwarded from the billing company to the Billing Operations Manager for posting. Payments to hearing aid manufacturers are posted to the billing system upon receipt of the hearing aid manufacturer invoice from the Audiology Program Director.

Chapter 5 Medical Records

5.1 Forms and Reports

As part of the patient intake process, all patients need to sign and date two required HIPAA forms:

- Notice of Privacy Practices Protected Health Information form (Form B.1)
- Release of Protected Health Information form (Form B.2)

Also included in the patient chart are the following forms:

- Patient registration demographic and financial information form (Form B.1.1)
- Photography release form (Form B.2.1)
- Clinical history form
- Consent form (B.1.2)
- Initial evaluations
- Session notes
- Discharge notes

Chart may also include:

- Referring clinician notes, letter, and reports
- Patient pre-visit questionnaire
- School/teacher correspondence

NOTE: Please refer to the Audiology Clinic handbook for further details.

5.2 Patient chart

5.2.1 Chart creation

Chart structure will be determined by each clinic based on the clinical needs of the specialty. In general each chart will be labeled with the patient's full name, the first 3 letters of the patient's last name, the year of the clinic visit (i.e. "12" for 2012). Some clinics may also add the name of the clinician and/or the specialty label.

Each side of the chart and the tabs/dividers included in the chart should be set up consistently across the clinic so that each type of patient information can be found quickly,

avoiding the need to look through the entire chart for information. See Appendix D for detailed description of each clinic/specialty chart structure.

5.2.2 Chart Pull

Patient charts should be pulled no less than one day prior to the patient's scheduled appointment to verify that the necessary referral or authorization has been obtained and any test results or updates are placed in the chart.

5.2.3 Chart Update

Updated clinical information, correspondence and other information regarding the patient should be date stamped and placed in the patient's chart within 2 business days of receipt.

5.2.4 Filing charts

All patient charts must be stored in a secure location in each clinic or in the medical records file room on the 7th floor. Charts should not be removed from the department for any reason except with the approval of the Dean.
NOTE: The Physical Therapy Clinic often uses WebPT online and store specific information on the WebPT web site. The CFCC uses a separate file room in the clinic to store discharged patient records.

5.3 Medical record copy requests

All requests for medical record information are processed by the Billing Operations Manager. In the absence of the Billing Operations Manager requests should be forward to the Assistant to the Dean for Clinical Affairs.

The Billing Operations Manager determines if the patient received care in the Allied Health Professions clinics on the date/s requested. If the patient was seen in an Allied Health Professions clinic, the request is forwarded to the Dran of the SAHP and then to LSUHSC legal counsel for approval to release the specified medical records. If approval is given, the Billing Operations manager retrieves the patient chart, determines the number of pages that will need to be copied, and advises the requesting party of the medical record fee amount. Reasonable copying charges are done in accordance with La.R.S. 40:1299.96 which provides in pertinent part: "If the original

treatment records are generated, maintained, or stored in paper form, copies shall be provided upon payment of a reasonable copying charge, not to exceed one dollar per page for the first twenty-five pages, fifty cents per page for twenty-six to three hundred fifty pages, and twenty-five cents per page thereafter, a handling charge not to exceed twenty-five dollars for hospitals, nursing homes, and other health care providers, and actual postage. The charges set forth in this Section shall be applied to all persons and legal entities duly authorized by the patient to obtain a copy of their medical records. If treatment records are generated, maintained, or stored in digital format, copies may be requested to be provided in digital format and charged at the rate provided by this Item; however, the charges for providing digital copies shall not exceed one hundred dollars, including all postage and handling charges actually incurred. If requested, the health care provider shall provide the requestor, at no extra charge, a certification page setting forth the extent of the completeness of records on file. In the event a hospital record is not complete, the copy of the records furnished shall indicate, through a stamp, coversheet, or otherwise, the extent of completeness of the records. Each request for records submitted by the patient or other person authorized to request records pursuant to the provisions of this Subparagraph shall be subject to only one handling charge, and the health care provider shall not divide the separate requests for different types of records, including but not limited to billing or invoice statements. The health care provider or person or legal entity providing records on behalf of the health care provider shall not charge any other fee which is not specifically authorized by the provisions of this Subparagraph, except for notary fees and fees for expedited requests as contracted by the parties." An invoice must be sent along with the University's tax ID number for reimbursement of the charges. Upon receipt of payment from the requesting party, a copy of requested medical record is made and mailed to the requesting party. A note is placed in the medical record indicating the release of medical records.

5.4 Clinician documentation

The following healthcare professionals are permitted to make entries in the patient's clinical record:

- Licensed Audiologists and students within the program
- Licensed Occupational Clinicians and students from an accredited Occupational Therapy/Occupational Therapy Assistant program;
- Licensed Speech Language Pathologists and students from an accredited Speech Language Pathology program;
- Licensed Physical Therapists and students from an accredited Physical Therapy program;
- Licensed Professional Counselors, interns on approved clinical assignment and students within and outside the program;
- Licensed Professional Psychologists, interns on approved clinical assignment and student within and outside the program;
- Other individuals as defined by the facility
- Every entry that is made into the clinical record will be signed with a legal signature – Legal first name or initial and full last name. Nicknames are not allowed. Professional's initials follow the last name indicating the professional's credential/s.

The signature of a student is always followed by a slash and then the signature of the supervising clinician. When an assistant makes an entry, a co-signature from the supervising clinician is required.

Chapter 6 Accounts Receivables

6.1 Claims

All insurance claim forms are generated by the designated billing company/organization to the appropriate insurance carrier.

6.2 Statements

All patient statements are generated by the designated billing company/organization to the appropriate insurance carrier.

6.3 Follow-up

6.3.1 Insurance

The designated billing company/organization is responsible for regularly reviewing each patient account for outstanding insurance claims, when appropriate contacting insurance company to determine the claim status, resubmitting denied insurance claims with updated billing and/or clinical information.

The Billing Operations Manager, with support from the clinic administrative staff and billing provider, is responsible for providing chart notes and documentation required to appeal and resubmit a denied claim.

The designated billing company/organization is responsible for regularly reviewing each patient account for outstanding account balances that are the patient's responsibility and contacting patient or guarantor by phone or in writing to collect the outstanding balance.

6.4 Semester Fees

Policy

To provide clients with a mechanism to pay for therapy services not covered by the client's insurance carrier, the SAHP Clinics have implemented a semester fee payment plan.

A client can be placed on a Semester Fee Payment Plan based on the following:

1. Client insurance benefit verification confirms that the therapy services needed are not covered by the insurance carrier, based on CPT and ICD-10 codes provided by the supervising clinician.

2. Therapy services billed to the client's insurance carrier/s are denied as non-covered service/s based on the CPT and ICD-10 codes billed by the supervising clinician.

Procedure

6.4.1 Semester Fee Form After a client has been identified as being eligible for the Semester Fee Plan the following steps must be completed:

1. The *Supervising Clinician* completes Client Information and Therapy Information sections with semester fee amount, number and frequency of therapy sessions on the Semester Fee Payment Agreement Form.
2. The *Supervising Clinician* signs the agreement and submits paperwork to the *Clinic Director*.
3. The *Clinic Director* completes the payment amounts on the form and forwards the signed completed form to the *Clinic Administrative Staff*.
4. *Clinic Administrative Staff* contacts client regarding Semester Fee payment plan and the amount due at the next appointment.
5. *Clinic Administrative Staff* obtains the client/guarantor signature on the payment Agreement Form at their next therapy appointment.
6. *Clinic Administrative Staff* files Semester Fee Request form on left side of client chart.
7. Semester Fee payments are tracked at a minimum of biweekly and recorded on the Semester Fee Payment Agreement form by the *Clinic Administrative Staff*.

6.4.2 Semester Fee Payment Schedule

The semester fee can be paid in full at the beginning of the semester or

The client/guarantor may according to the schedule described on the Semester Fee Request form. The client/guarantor will be allowed to pay 25%, of the total semester fee on the first day of therapy for the semester or the next therapy session after the insurance denial is posted to the billing system. The remaining 75% will be paid on 3 pre-determined installment dates described on the Semester Fee form, typically, the first of each of the months following the initial payment.

The full balance will need to be paid in full by the 4th installment date of the current semester. In order to be placed on the therapy schedule for the subsequent semester, all outstanding account balances must be paid in full by the last installment date.

6.5 Bad Debt

6.5.1 Patient Responsibility

Account balances that are the patient/guarantor responsibility that are greater than 120 days in Accounts Receivable are placed with an outside collection agency. Write off and/or discounts are at the discretion of the clinician and/or Department Head/Program Director.

6.5.2 Denied Insurance

When an invoice has been denied by insurance due to reasons including, but not limited to, untimely filing, missing authorization, and missing clinician referral, the invoice is written off according to the appropriate adjustment code set up in the billing system.

6.6 Credit Balances

Billing Operations Manager reviews accounts with invoice credit balances on a monthly basis to determine if patient accounts are still active and has an outstanding balance on other dates of service to which the overpayment need to be applied. When the account is no longer active and/or account has a net credit balance, Billing Operations Manager will submit a refund request to LSUHSC Accounting Services. Upon receipt of refund check Billing Operations Manager will submit a request to the billing company to post a refund to patient invoice/s in the billing system. The refund check will be mailed to the appropriate party.

Chapter 7 Infection Control

7.1 Universal precautions

1. Faculty, staff and students must annually verify that they are clear of communicable diseases and are up to date on required vaccinations and immunizations

2. Weekly the assigned office staff, students and clinicians will disinfect toys, patient contact surfaces and equipment in the examination and reception areas per instructions. When a patient is observed coughing, mouthing or drooling near toys, clinic equipment and /or other common area surfaces, the object will be removed, if possible, for cleaning. If the object cannot be removed, the clinic employee, student or clinician should disinfect the surface immediately.

3. Weekly assigned clinicians will disinfect all hard surfaces in the audiology suite and clean immittance tips per instructions.

4. On a daily basis student clinicians are responsible for disinfecting tables in Speech treatment rooms with germicidal spray after each treatment or diagnostic session. Instruments, toys and test materials that are utilized during a diagnostic or treatment session must be disinfected after the session is completed.

5. Audiology probe tips and ear specula need foam earphone inserts must be discarded after use.

6. Custodial staff is responsible for removing trash from each treatment room and the audiology suites on a daily basis.

7. Hand washing is required before and after every patient session. Hands should be washed immediately within the session if there is contact with any bodily fluids. Refer to posted instructions for hand washing.

8. Gloves are required on both hands when performing oral mechanism examination, oral motor therapy, feeding therapy, tracheoesophageal puncture(TEP) or laryngectomy therapy.

9. When necessary, patient diapers should be changed by a family member of the patient.

7.2 General Clean-up

7.2.1 Clinicians evaluating and treating patients in the clinic facilities are responsible for keeping the clinic area tidy and equipment working properly by doing the following:

- Check and return materials/equipment to appropriate location.
- Leave the clinic rooms in order. Return tables, chairs and other furniture to the designated location following the session. Request vacuuming or more extensive cleaning as needed.
- Inform clinic staff or the designated faculty of missing items or items that need to reordered, replaced or repaired.
- Communication Disorders clinic clean-up schedule will be disseminated each semester.
- Complete an equipment malfunction report on any malfunctioning instruments or equipment and give to clinic supervisor.

Chapter 8 Safety and Facilities

Emergency Contact Numbers

Life-threatening medical emergency	**911**
Fire	**911**
LSUHSC University Police	**3-8999**
Poison Control	**800-POISON or 800 356-3232**
Suicide Prevention Center	**3-3931**
Emergency Clinician on Call	James Diaz, MD 568-6052
LSUHSC Environmental Health and Safety Office	**3-6586**
LSUHSC Facilities	**3-7716**

Note: To be posted in the reception area in clear view of all employees, visitors, and interested individuals.

For information on safety responsibilities related to biological, chemical and fire safety policies and emergency procedures see http://www.is.lsuhsc.edu/safety/default.aspx

For information on campus security and emergency response see http://www.is.lsuhsc.edu/police/

Chapter 9 Disaster Plan

For weather related emergencies see the LSUHSC policies and procedures at:

http://www.lsuhsc.edu/no/administration/cm/cm-51.aspx

Appendices

Appendix A

1. Bylaws and Regulations of the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College

http/www.lsuhsc.edu/administration/subscriptions/

2. LSU System Permanent Memoranda

http://www.lsuhsc.edu/administation/pm/

3. LSUHSC – New Orleans Chancellor Memoranda

http://www.lsuhsc.edu/administration/cm/

4. Office of Compliance Programs

http://www.lsuhsc.edu/no/administration/ocp/

Appendix B – Patient Forms

B.1 Required Forms

- B.1.1 Patient Registration/Update
- B.1.2 Patient Consent to Treat
- B.1.3 Notice of Privacy Practices
- B.1.4 Acknowledgment of Receipt of Notice of Privacy Practices

B.2 Additional Clinic Forms

- B.2.1 Consent to Photograph, Videotape, Audiotape
- B.2.2 Insurance Verification Form – Evaluation/Re-evaluation
- B.2.3 Insurance Verification Form – Therapy/Treatment
- B.2.4 Authorization to Release Protected Health Information
- B.2.5 Authorization to Release Medical Record Information
- B.2.6 Daily Clinic Sign-in Sheet
- B.2.7 Chart Audit Checklist

B.3 Audiology Forms

B.4 Child and Family Counseling Forms

B.5 Occupational Therapy Forms

B.6 Physical Therapy Forms

B.7 Speech-Language Pathology Forms

Clinic and Operations website forms:
https://alliedhealth.lsuhsc.edu/clinics/clinicforms.aspx

Appendix C – Billing Operations Forms

C.1 Receipts

C.2 Daily Deposit Worksheets

C.3 Charge Slips

School of Allied Health Professions
Patient Registration/Update

☐ New Patient ☐ Update

Last Name	First Name	Middle Name

☐ Female ☐ Male

___/___/___ Date of Birth

___-___-___ Social Security Number

Marital Status: ☐S ☐M ☐ D

Patient's Street Address	City	State	Zip	Phone Number ( )

Responsible Person's Name	Relationship to Patient	E-mail address

Responsible Person's Address	City	State	Zip	Phone Number ( )

Responsible Person's Employer Address	City	State	Zip	Phone Number ( )

Emergency Contact Name	Relationship	Phone Number ( )

Primary Insurance

Insurance Company Name	Contract/Certificate #	Policy or Group #

Insurance Company Address	City	State	Zip	Phone Number ( )

Relationship to Subscriber	Subscriber Name	Subscriber Social Security #

Subscriber's Employer	Employer's Phone Number ( )

Secondary Insurance

Insurance Company Name	Contract/Certificate #	Policy or Group #

Insurance Company Address	City	State	Zip	Phone Number ( )

Relationship to Subscriber	Subscriber Name	Subscriber Social Security #

Subscriber's Employer	Employer's Phone Number ( )

For Office Use Only

Appointment Date:______________________________ Account #: ____________________________

Clinician:____________________________________ Referring Provider: ____________________________

Patient Consent for Treatment

I do hereby voluntarily consent to such treatment as is deemed necessary by the clinician. I hereby release Louisiana State University Health Sciences Center and its personnel from any responsibilities resulting from illness, ill effect, or reaction from the treatment ordered by my physician.

Patient Guarantee and Authorizations

In consideration for and to cause Louisiana State University Health Sciences Center School of Allied Health Professions Clinics to treat ____ (print patient name) as a private patient, the undersigned hereby unconditionally guarantees payment of all cost charges and expenses of the Louisiana State University Health Sciences Center School of Allied Health Professions Clinics to apply for benefit on my behalf for covered services rendered by the LSU School of Allied Health Clinics, and request all payments be made to "LSUHSC." Furthermore, I understand and agree any unpaid balance not covered by my insurance policy will be paid directly by me.

Insurance forms are mailed to:
(Please indicate with a check)

- Employer ☐
- Insurance Company ☐
- Other (specify) ☐ ______________________

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care procedures. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read all of the above, and I certify that I understand its contents.

______________________________________ ______________________
Patient's Signature Date

______________________________________ ______________________
Other Authorized Signature Date

______________________________________ ______________________
Relationship of Authorized Signature Reason Patient Cannot Sign

In case of emergency, please contact:

______________________________________ ______________________
Name/Relationship Telephone Number

Revised 10/27/15

LSU Health NEW ORLEANS

Notice of Privacy Practices Protected Health Information

This Notice Describes How Your Medical/Dental Information May Be Used and Disclosed and How You Can Get Access to this Information. Please Review it CAREFULLY.

The law requires us to make sure your medical information is kept private. It also requires us to give you this notice of our legal duties and privacy practices to tell you what we can do with the medical information about you. To better understand this law, you may want to read it. It is in Title 45 of the Code of Federal Regulations, Part 164. In the unlikely event that the information we have about you should be obtained by someone who is not supposed to have it, the law requires us to notify you. We are required to follow the practices outlined in this notice. We have the right to change this notice and our privacy practices in the future. Any changes made will apply to all of the medical information we have about you at this time. If we make a change, we will put up a notice in our building. We will also give you a copy of the new notice if you ask for it. You can also read about these changes on the computer at this website: www.lsuhsc.edu.

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE USED: In general, we may use your medical information in a number of ways:

To provide patient care to you. Your medical information may be used by the doctors, nurses and other professionals who are treating you. For example, your medical information is used to help them find out your problems or condition, and to decide the best way to treat you. Appointment Reminders. We may use your medical information to contact you to remind you of appointments, and to give you information about other treatment options, or other health – related benefits and services that may be of interest to you.

Appointment reminders. We may use your medical information to contact you to remind you of appointments, and to give you information about other treatment options or other health-related benefits and services that may be of interest to you.

To obtain payment. Your medical information may also be used by our business office to prepare your bill and process payments from you as well as from any insurance company, government program or other person who is responsible for payment.

For our health care operations. Your medical information may be used to review the quality and appropriateness of the care you receive. We may also use your medical information to put together information to see how we are doing and to make improvements in the services and care we give you. In some cases we may have students, trainees, or other health care personnel, as well as some non-health care personnel, who come to our facility to learn under the guidance of faculty to practice or improve their skills.

To create de-identified databases. We may use your medical information for the purpose of removing your personal information that tells anyone who you are, and putting it into a computer program. Your information may be completely de-identified where all identifying information is removed or partially de-identified but includes information such as gender and zip codes. This information is often used for research purposes. If your information is partially de- identified, it is called a "limited data set."

Fundraising. We may use your medical information to raise funds for our organization directly or to raise funds for our organization through an institutionally – related foundation or business associate. You may receive communications about these fundraising activities. You have the right to request that you not be contacted by us for purposes of fundraising and we must agree to your request.

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE DISCLOSED: In addition to using your medical information, we may disclose all or part of it to certain other people. This includes giving your information to:

You. In order to get your medical information, you will need to fill out an authorization form. You may also have to pay for the cost of some or all of the copies.

People You Authorize. If you tell us that you want us to give your medical information to someone, we will do so. You will need to fill out an authorization form. We must obtain your written authorization before disclosing information you may have shared with one of our psychiatrists, psychologists or counselors in a private session, or to use your information to market our services, or to sell your information. We must obtain your authorization to use or disclose your information in any way that is not otherwise described in this notice. You may stop this authorization at any time. We are not allowed to force you to give us permission to give your medical information to anyone. We cannot refuse to treat you because you stop this authorization.

Payers. We have the right to give your medical information to insurance companies, government programs such as Medicare and Medicaid, and their contractors who process your claims, as well as to others who are responsible for paying all or part of the cost of treatment provided to you. For example, we may tell your health insurance company what is wrong with you and what treatment is recommended or has been given to you.

Business Associates. Business Associates are companies or people we contract with to do certain work for us. Examples include billing services, information auditors, attorneys and specialized people providing management, analysis, utilization review or other similar services to us. Another example is giving health information to a Business Associate so that they can create a de-identified database. All Business Associates are required to agree to take reasonable steps to protect the privacy of your medical information.

Limited Data Set Recipients. If we use your information to make a "limited data set," we may give the "limited data set" that includes your information to others for the purposes of research, public health action or health care operations. The persons who receive the "limited data set" are also required to agree to take reasonable steps to protect the privacy of your medical information.

The Secretary of the U.S. Department of Health and Human Services. The Secretary has the right to see your records in order to make sure we follow the law.

Public Health Authorities. We may disclose your medical information to a public health authority responsible for preventing or controlling disease, maintaining vital statistics or other public health functions. We may also give your medical information to the Food and Drug Administration in connection with FDA-regulated products.

Law Enforcement Officers. We may reveal your medical information to the police. We may also give your medical information to persons whose job is to receive reports of abuse, neglect or domestic violence. And, if we believe that releasing this information is needed to prevent a serious threat to the health or safety of a person or the public, we are permitted to reveal your medical information.

Health Oversight Agencies. We may give your medical information to agencies responsible for health oversight activities, such as investigations and audits, of the health care system or benefits programs, as allowed by law.

Courts and Administrative Agencies. We may reveal your medical information as required by a judge for a legal issue.

Coroners and Administrative Agencies. If you die, we may reveal medical information about your death to coroners, medical examiners and funeral directors, as allowed by law.

Tissue Donation and Organ Transplant Services. We may reveal your medical information to agencies that are responsible for obtaining tissue donations and obtaining and transplanting organs.

Research. We may reveal your medical information in connection with certain research activities. With your authorization, we may disclose pertinent information such as your name, social security number, study name, and dates of participation to our Accounts Payable department to issue human subjects research incentive payments.

Specialized Governmental Functions. We may disclose your medical information for certain specialized governmental functions, as allowed by law. Such functions include:

- Military and veteran activities
- National security and intelligence activities
- Proactive services to the President and others
- Medical suitability determinations; and
- Correctional institutions and other law enforcement custodial situations.

Required by Law. We may also reveal your medical information in any other circumstances where the law requires us to do so.

OBJECTIONS TO USES AND DISCLOSURES: In certain situations, you have the right to object before your medical information can be used or revealed. This does not apply if you are being treated for certain mental or behavioral problems. If you do not object after you are given the chance to do so, your medical information may be used:

Patient Directory. In most cases, this means your name; room number and general information about your condition may be given to people who ask for you by name. Also, information about your religion may be given to members of the clergy, even if they do not ask for you by name.

Family and Friends. We may disclose to your family members, other relatives and close personal friends, any medical information that they need to know if they are involved in caring for you. For example, we can tell someone who is assisting with your care that you need to take your medication or get a prescription refilled or give them information about how to care for you. We can also use your medical information to find a family member, a personal representative or another person responsible for your care and to notify them where you are, about your condition or of your death. If it is an emergency or you are not able to communicate, we may still give certain information to persons who can help with your care.

Disaster Relief. We may reveal your medical information to a public or private disaster relief organization assisting with an emergency.

YOUR RIGHTS REGARDING YOUR MEDICAL/DENTAL INFORMATION: You may also have the following rights regarding your medical information:

You have the right to ask us to treat your medical information in a special way, different from what we normally do. Unless it is one of the uses or disclosures to which the law gives you the right to object, we do not have to agree with you. If we do agree to your wishes, we have to follow your wishes until we tell you that we will no longer do so. However, you have the right to request restrictions on disclosures of information about a health care item or service for which you have paid in full out of pocket. We must agree to your request as long as the requested restriction applies to seeking payment or our health care operations and not required by law.

You have the right to tell us how you would like us to send your information to you. For example, you might want us to call you only at work or only at home. Or you may not want us to call you at all. If your request is reasonable, we must follow your request.

You have the right to look at your medical information and, if you want, to get a copy of it. We can charge you for a copy, but only a reasonable amount. Your right to look at and copy your medical records is based upon certain rules. For example, we can ask you to make your request in writing, or, if you come in person, that you do so at certain times of the day.

You have the right to ask us to change your medical information. For example, if you think we made a mistake in writing down what you said about when you began to feel bad, you can tell us. If we do not agree to change your record, we will tell you why, in writing, and give you information about your rights.

You have the right to be told to whom we have given your medical information in the six years before you ask. This does not apply to all disclosures. For example, if we gave someone your medical information so that they could treat you or pay for your care, we do not have to keep a record of that.

You have the right to get a copy of this notice at no charge.

You have the right to complain to us or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights.

If you have a complaint or concern, please call our
24 hour Hotline: (504) 568-2347
Your call will be handled by our Privacy Officer.
You may remain anonymous and all calls are kept confidential.

For further information about your rights or about the uses and disclosures of your medical information, please call
The Office of Compliance Programs at: (504) 568-5135
to speak with either our Compliance or Privacy Officer.
Or write to:
LSUHSC New Orleans
Office of Compliance Programs
433 Bolivar Street, Room 807
New Orleans, LA 70112

Or email:
nocompliance@lsuhsc.edu

This notice is effective as of 4/13/2003 and revised as of 9/23/2013

School of Allied Health Professions

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____________________________________, acknowledge that I have received a copy of
(Patient's name – please print)
the Notice of Privacy Practices of LSUHSC--New Orleans on this date.

______________________________________ Date: ____________________
Signature – Patient or Patient's Representative

Health Care Provider's Documentation of Good Faith Effort to Obtain Acknowledgement of Receipt

If the Acknowledgement could not be obtained prior to the date of first service to the patient, or, in an emergency situation, as soon as reasonably practicable after the emergency has resoled, describe below the efforts made to obtain the written Acknowledgement and the reasons why the written Acknowledgement could not be obtained. If the patient refused to provide the written Acknowledgement, please so state.

Efforts to obtain written Acknowledgement:

____

____

____

____

Reasons written Acknowledgement could not be obtained:

____

____

____

______________________________________ Date: ____________________
(Signature of healthcare provider)

____
(Printed name of healthcare provider)

Revised 1/20/16

LSU Health New Orleans
HEALTH SCIENCES CENTER

Consent to Photograph, Videotape, Audiotape

I give permission to Louisiana State University Health Sciences Center (LSUHSC) to photograph, videotape, or audiotape me and/or my child, ____, during evaluation and treatment sessions. I understand that these may be used for teaching, professional presentations or for publication. Photographs and tapes will be the property of the department and will be held in confidence. In some instances, the name of you or your child may be used.

Please indicate any restrictions below or strike out and initial any exclusions.

____

____

____

____

Name: ____

Address: ____

____

Phone: ____

____ ________________________

Signature **Date**

Insurance Verification Form – Evaluation/Re---evaluation

General Information

☐ Initial Evaluation ☐ Re---evaluation Requested By: ____________________

Date of Request: ______________ Appointment Date: ____________________

Patient Name: ______________________________________ DOB: ____________

Patient Address: ____

Patient Phone #: __________________________ Relationship to Insured: ______________

Insured Name: ______________________________________ Insured DOB: ____________

Insurance Company Name: ____

Insured Employer: ___________________________________

Policy or Claim #: ______________________________ Group #: ____________________

Insurance Information

Phone # Called: __________________________ Date Called: __________________

Spoke to: ________________________________ Primary Ins: ☐ Yes ☐ No

In Network: ☐ Yes ☐ No Prescription Required: ☐ Yes ☐ No

Coverage Effective Date: ______________ Period: ☐ Calendar ☐ Contract

Type of insurance/Payor: ☐Commercial ☐Worker's Comp ☐ Auto ☐Other ______________

Deductible Amount: __________________ Deductible Met: ☐ Yes ☐ No Amount Met: __________

Co---Pay Amount: ________________ Benefits: _______________________________________

Pre---certification/Authorization

Authorization #: __________________________ Medical documentation required: ☐Yes ☐No

Number of Visits Authorized: _________________

Start Date: ____________________ Expiration Date: ____________________

Case Manager Name: ______________________

Phone #: ___________________________ Fax #: ______________________________

Adjuster Name: __________________________

Phone #: ___________________________ Fax #: ______________________________

Billing Information

Mail claim to: ____

____

Comments: ____

____

Verified by: ______________________________ Date: ________________________

Insurance Verification Form – Therapy/Treatment

☐ Initial Therapy ☐ Extend # of therapy visits/date range Requested By: ___________________

Date of Request: _________________ Next Appointment Date: _______________________

Patient Name: ____ Account #: _______________

Therapy Information

CPT code/s: _____________ ICD---10 Codes: _____________________

_____________ _____________________

_____________ _____________________

_____________ _____________________

Number of therapy sessions: _____________ Therapy session frequency: _____________________

Insurance Information

Phone # Called: _______________________________ Date Called: _________________

Spoke to: ____________________________________ Primary Ins: ☐ Yes ☐ No

Coverage Effective Date: ________________ Period: ☐ Calendar ☐ Contract

Type of insurance/payor: ☐Commercial ☐Worker's Comp ☐Legal ☐Other _____________

Deductible Amount: ____________________ Deductible Met: ☐ Yes ☐ No Amount Met: __________

Co---Pay Amount: ___________________ Benefits: ____

Pre---certification/Authorization

Authorization #: ______________________________ Medical documentation required: ☐Yes ☐No

Number of Visits Authorized: ___________________

Start Date: ______________________ Expiration Date: ________________________

Case Manager Name: ____

Phone #: ______________________________ Fax #: _________________________________

Adjuster Name: ____

Phone #: ______________________________ Fax #: _________________________________

Billing Information

Mail claim to: ____

____

Comments: ____

____

Verified by: __________________________________ Date: ___________________________

Revised 11/2/2015

Authorization for Release of Protected Health Information

ATTACHMENT B

Make two copies. Provide one to patient. Maintain original in LSUHSC-NO Files.

Patient Name: ______________________________ Date of Birth: ___/___/___
Address Street____
City/State/Zip ______________________________________
Telephone: ______________

Authority to Release Protected Health Information

I hereby authorize ______________________________ to release the information identified in this authorization form from the medical records of ________________ and provide such information to ____________________.

Information to be Released – Covering the Periods of Health Care: From (date) ___/___/___ to (date) ___/___/___
Please check type of information to be released:

__Complete health record	__Diagnosis & treatment codes	__Discharge summary	__Psychotherapy Notes
__History and physical exam	__Consultation reports	__Progress notes	(*If above is checked, any other PHI*
__Laboratory test results	__X-ray reports	__X-ray films / images	*must be listed on a separate*
__Photographs, videotapes	__Complete billing record	__Itemized bill	*authorization form*)

__Other, (specify) ____

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual"):____
____

If this authorization is for the purposes of marketing or the sale of PHI, will LSUHSC-NO receive any payment as a result of this authorization? Check One: ___Yes ___No ____Initials

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: _____Yes ___No
I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. Check One: ___Yes ___No

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to ____________________ at ____________________. Unless revoked, this authorization will expire on the following date, or after the following time period or event ____________________.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge LSUHSC-NO and its officers, directors, employees and students of any liability and the undersigned will hold them harmless for complying with this Authorization.

Signature: ________________________ Date: ___/___/___
Description of relationship if not patient:______________________________

School of Allied Health Professions

PATIENT'S REQUEST FOR ACCESS TO AND OBTAIN A COPY OF THEIR PROTECTED HEALTH INFORMATION

Patient:

I, ______________________________________, request access to my protected health information contained in the medical records or billing records maintained by LSUHSC--NO to review the contents and obtain copies.

OR

Patient's Personal Representative:*

I, ______________________________________, request access to the protected health information of ______________________________________ contained in the medical records or billing records maintained by LSUHSC--NO to review the contents and obtain copies.

I have the right to inspect and request copies of whatever portions or the entirety of the health records as well as to request a summary explanation of these records and that LSUHSC--NO will arrange a convenient time and place for me to conduct my review of this protected health information. I request access and/or copies/summaries of the following information:

From (date): __________________________

To (date): __________________________

Please check the type of information to be accessed/copied:

- ☐ Complete medical Record
- ☐ Diagnosis & treatment codes
- ☐ Discharge summary
- ☐ History & physical exam
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Photographs, video
- ☐ Complete billing record
- ☐ Itemized bill
- ☐ Other _________________

I would like this information provided to me by the following method (check one):

- ☐ Person pick--up
- ☐ U.S. Postal service to:

Address: ____

____

Signature: ____

Date: __________________________

*Individual must be listed as an authorized person by the patient on the HIPAA Release of Protected Health Information form.

Revised 11/17/15

Daily Clinic Sign In Sheet

Please Sign In	**Date:**
Patient Name (Please Print)	Patient Name (Please Print)

Date of Service: ___________ Account #: _________________________ Patient Initials:_____________

Item	Completed (Yes/No)	Notes	Verified By (initials)
Patient registration form	☐ Yes ☐ No		
Patient Consent to Treat	☐ Yes ☐ No		
Notice of Privacy Practices	☐ Yes ☐ No		
AV recording form	☐ Yes ☐ No		
Authorization to release medical records form	☐ Yes ☐ No		
Copy of insurance card	☐ Yes ☐ No		
Copy of picture ID	☐ Yes ☐ No		
Insurance verification	☐ Yes ☐ No		
Patient history	☐ Yes ☐ No		
Signed clinic note by billing clinician	☐ Yes ☐ No		
Completed charge ticket submitted	☐ Yes ☐ No		
Patient sign-in verified	☐ Yes ☐ No		
CMS claim form (hearing aids only)	☐ Yes ☐ No		

Chart Review completed by: ____ Date: ____________________

Revised 11/4/15

LSUHSC Audiology Case History (Adult)

Name: ________________________ Age:___________ Date of Birth: ______________

Referred by: ____________________

How can we help you today? Primary Complaint?

Have you had your hearing evaluated before? _________ yes _________no

If so, by whom and when: ____

Which ear are you most concerned about? Right_______ Left_______ Both ________

Has the hearing loss been: Gradual?_____ Sudden? _________ Fluctuating? _________

Does anyone in your family have a hearing problem? Yes ________ No ________

Have you been exposed to loud noises? Yes________ No ________

Do you hear noises ringing noises in your ear or head? Yes__________ No _________
How Often?

Do you ever have a feeling or fullness or stuffiness in your ears? Yes________ No_________

Are you ever dizzy, unsteady, or off balance? Yes_________ No __________

Is your dizziness caused by: Nausea? Yes _____ No _________
Vomiting? Yes _____ No _________

Have you ever had ear surgery? Yes ________ No ________

Do you have a history of Ear Infections? Yes _____ No ________

Primary Care Physician____ Address: ________

For Patient

Tinnitus Reaction Questionnaire (TRQ)

Name: ____ Date Completed: ____________________

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that best reflects how your tinnitus has affected you **over the past week.**

	Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has "driven me crazy".	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel helpless.	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18. My tinnitus has interfered with my ability to work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4
Total					

Over the past week, what percentage of time were you aware of your tinnitus?	%
During the time that you were aware of your tinnitus, what percentage of that time was it bothersome?	%

Tinnitus History Questionnaire

Name ______________________________________ ___

DOB: _________ Date Completed:________________

Nature of the Tinnitus

How does the tinnitus sound? ______________________________

Usual site of the tinnitus? (circle) Left = Right | Left worse than Right | Right worse than Left | Central

Is the tinnitus constant or intermittent? ______________________________

Does the tinnitus fluctuate in intensity or loudness? ______________________________

What makes your tinnitus worse? ______________________________

What makes your tinnitus better? ______________________________

Tinnitus History

When did you first become aware of your tinnitus? ______________________________

When did your tinnitus first become disturbing? ______________________________

Under what circumstances did the tinnitus start? ______________________________

What do you consider to have started the tinnitus? ______________________________

Who have you consulted about your tinnitus? ______________________________

What have previous professionals said your tinnitus is due to? ______________________________

What treatments have you tried for your tinnitus?

- [ ] None
- [ ] Hearing Aid
- [ ] Masker
- [ ] TRT
- [ ] Counselling
- [ ] Music Therapy
- [ ] Other - please comment ______________________________

How successful did you find these treatments? ______________________________

____

____

Tinnitus History Questionnaire

Name____________________
Date Completed____________________

Have you ever:	Y/N	Details/Comments
Been exposed to gunfire or explosion? How often were you exposed? Did you wear hearing protection?		
Attended loud events? (e.g., concerts, clubs)		
Had any noisy jobs?		
Had any noisy hobbies or home activities?		
Had any head injuries or concussion?		
Had any operations involving your ear or head?		
Used solvents, thinners or alcohol based cleaners?		
Taken any of the following medications: Quinine, Quinidine, Streptomycin, Kanamycin, Dihydrostreptomycin, Neomycin		

Do you:	Y/N	Details/Comments
Have loose dentures, jaw pain or grinding and clicking sensations in the jaw?		
Regularly take aspirin or dispirin?		
Have any feelings of ear pressure or blockage?		
Do you find exposure to moderately loud sounds make your tinnitus worse?		
What is your current occupation?		

General Hearing Problems

	Y/N	Details/Comments
Do you have any difficulties hearing when there is background noise?		
Do you have difficulties understanding in one-to-one conversations?		
Do you have difficulties hearing the TV?		
Do you have difficulties hearing on the telephone?		
Do you have any dizziness or balance problems?		
Do you find external sounds unpleasant or uncomfortable?		
Do you dislike certain external sounds?		
Do you wear ear protection / ear plugs?		

Tinnitus History Questionnaire

Name____________________
Date Completed____________________

Please rank the auditory problems you experience from most troublesome (1) to least troublesome (3)

	Hearing Loss
	Tinnitus
	Sensitivity to Loud Sounds

Effect of the Tinnitus

	Y/N	Details/Comments
Does your tinnitus prevent you from getting to sleep at night?		

How many times per night did you awake in the last week? ____________________

How has tinnitus affected your work life? ____________________

How has tinnitus affected your home life? ____________________

How has tinnitus affected your social activities? ____________________

General Health

What is your general health like? ____________________

Are you taking any medications? If yes, please specify. ____________________

____

Compensation

	Y/N	Details/Comments
Are you currently pursuing any form of compensation, sickness benefit, DVA, motor vehicle accident claim or any other legal action in relation to your tinnitus?		

Medical Contact Details ____________________

Name and Address of GP ____________________

Name and Address of ENT ____________________

I give consent to release results to my GP /ENT Signed: ____________________

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?

Child and Family Counseling Clinic

411 S. Prieur St., Room 307

New Orleans, LA 70112

(504) 556-3451

Fax # (504) 556-7540

Email: cfcc@lsuhsc.edu Web: http://lsuh.sc/cfcounselingclinic

NEW PATIENT CONTACT FORM

Date : ______________________________

Name of Person Providing Information: ______________________________

Relationship to Child: ______________________________

Caregiver(s) Name: ______________________________ Phone #: ______________________________

Name: ______________________________ Phone #: ______________________________

Name: ______________________________ Phone#: ______________________________

Email: ______________________________ Other Emergency # : ______________________________

Child's Name: ______________________________ **DOB:** ______________________________

Referred by Name & Phone# : ______________________________

Relationship to Child: ______________________________

Presenting Issue(s): ______________________________

____

____

____

____

____

How long have issue(s) been presenting: ______________________________

____

In which environments are the presenting issues affecting: Explain

_______ School _______ Home _ Social _ Other

____

____

Has your child received any of these professional services in the past?

_______ Counseling _______ Play Therapy ________ Group ________ Psychologist

_______ Psychiatrist _______ Office of Child Services

Does your child have a current diagnosis if yes:
What is the diagnosis_________________who evaluated____

Insurance Information

____
Responsible Person Name Address City State Zip Phone #

Insurance Company: ___________________ Member ID#: ________________________

Ins. Phone ________________________________ Employer name ________________________________

Availability to bring child in: (check one)

_______ Monday _______ Tuesday ___ Wednesday ____ Thursday

Times: earliest ___ latest _ open ________

What time does your child get out of school each day? ______________

Any other relevant information:

____

____

____

Custody Information:

____

____

____

OCS involvement:

____

____

____

LSUHealthNewOrleans
School of Allied Health Professions

LSUHSC Child and Family Counseling Clinic

Biopsychosocial History Information

Today's Date: ________________

CHILD'S DEMOGRAPHICS

Child's Name: ________________________ Sex: __M or F__ Birth Date:____________________

Age: ________________ School: ______________________________ Grade: _____________

Teacher's Name: _______________________ Phone: ____________ Email: ________________

School Counselor's Name: _____________________________Email: ____________________________

Person filling out this form and relationship to child:__________________________/______________

Who referred you? ________________________Relationship of the referral to your child?___________

Parent #1
Name: _________________________
Age: _______________
Occupation: ___________________________

Parent #2
Name:______________________________
Age: _________________
Occupation: __________________________________

Other Parents Information(include ALL caregivers who provide daily/weekly care for your child):
Name/Age/Occupation:____
Name/Age/Occupation: ____

Based on the reason for referral of the person who referred you/your child for services, do you agree with the referral? Y or N
Please explain: ____

____
____.

Is this referral related to any type of legal or court proceedings? Y or N
If yes, please explain:

____
____
____.

Do you plan to have me testify in court proceedings? Yor N
If yes, please explain:

____
____
____.

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PRESENTING ISSUE(S):

Briefly describe your child's current difficulties: ____
____
____
____

How long has child had problem(s) for which you are seeking help?

____0-1 month ____1-3 months _____3-6 months ____6-12 months ____1-2 years _____2-4 years

Other: (please indicate) ____

Please rate the intensity of the problem(s) or concern(s) that you have in reference to your child? (Circle a number)

1 ________ 2 ____________ 3_____ ________ 4 _________5
Low High

Please indicate the frequency with which the problem(s) occur:

____daily ____weekly ____monthly ____seasonal ____specific event(s) _____specific place(s)

____other ____

Describe the behaviors of your child and the impact on the following environments (please describe the most recent period(s) of time):

Home:____
____
____

School:____
____
____

Other social environments:
____
____
____.

What have you done in an attempt to resolve the problem and what results/outcomes and what changes have developed in response to the problem over time? Please explain in detail:
____
____
____
____

Has your child been seen previously by a:

Professional	Yes	No	Name of Professional	Date(s) of Service	# of sessions	Currently Seeking Services Y or N	If yes, Frequency (days of the week, times)
Psychiatrist							
Psychologist							
Speech Pathologist							
Audiologist							
Physical Therapist							
Occupational Therapist							
Social Worker							
School Counselor							
Learning Specialist							
Tutor							
ABA Therapist							
Hospitalized for Psychiatric Care							
Other							

Is your child adopted? ________ Yes_________ No Date of adoption: _________________

If yes, was the adoption open or closed? ______________________

If yes, what does your child know (if anything) about his/her adoption? __________________________________
____
____.

FAMILY HISTORY

Marital Status of Parents: ___Married _____Separated ____Divorced ____Never Married/Living Together

_____Never Married/Living Apart _____Remarried ____Other __________________________________

If parents are separated or divorced, how old was child when the separation occurred?_____________________

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Please describe events which led up to the divorce and events that your child was exposed to (include arguments, fighting, violence if applicable, etc)____

____

____

____.

The next set of questions primarily focuses on children whose parents have/are separated and/or divorced:

What is the custody schedule? ____

Which adult does your child live with? ____

How long has this current situation been? _____________________________________

Is your child happy/content with this situation? __________________________________

Why & How Can You Tell? ____

____

____.

For all parents:
Describe your current spousal relationship (applicable for parents who are married, not married, separated and/or divorced):

Whom is your child closer with (parent/grandparent/other)?

____

Would you describe your child as "distant" from any one particular parent/grandparent/other?

____

Family Constellation: (List all people living in household. Include all family members (parents, siblings) that have frequent contact with child (i.e., weekly, and bi-weekly) such as maternal grandmother, half siblings, stepmother, etc.)

Name	Relationship to Child	Age	Frequency

Describe your child's daily and weekly routine: (school schedules, activity schedules, other):____

____

____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Wake Time							
Morning Routine							
School Times							
After School Event/Times							
Evening Routine							
Bed Time							

Who is primarily responsible for your child? (mom? Dad? Both? Describe): ______________________________
____
____.

What kind of physical exercise does your child get? ____

What kind of play is your child involved in? ____

____.

What kind of "down" (i.e., no physical activity, TV, Screen time) time does your child get? How long?
____

What kind of screen time does your child get? How long? What does he watch? What does he play?
____

How much caffeine does your child consume each day? ____

Does your child have access to weapons? (y/n)____

Has your child ever made an attempt to harm him/herself, or others? Threatened to do so? Explain.
____
____

Difficulty with Siblings? (Arguing, fighting, jealousy)____
____
____

Method of Discipline Currently Used (include both caregivers):

_____spanking ___fussing ____screaming ____taking privileges away ___Timeout

____rewards ___other ____

Is your method of discipline effective? ____

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Who is the main disciplinarian at home? ____

Do both parents discipline similarly? Differently? ____.

Have there been any recent changes in the family system and if yes for how long? (i.e., change in home location, major events, significant losses, etc.)

____

____

____.

_____# of times the family has moved since the child was born? Reasoning: ______________________________

____.

Family Religion: ____Catholic ____Protestant ____Jewish ____Lutheran ___Episcopalian

____Non-Denomination ____Atheist ____Science Christian ____Other

Are there any cultural/spiritual beliefs that you may have that you believe will impact your child's therapy?____

____.

Check the activities in which your child participates with the family:

Activity	Y or N	Frequency	Level of Child's Enjoyment
Movies			
Meals			
Conversations			
Visits with Relatives			
Church			
Games			
Sports			
Trips			
TV			
Out to Dinner			
Other			

What do you feel your strengths as a family are? ____

____

What would you like to change in your family? ____

____

What do you enjoy most about this child?

____

____

____.

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What do you find most difficult about raising this child?
____
____
____.

What would you like for your child to be when he/she grows up? ________________________________.

Highest grades completed in years: ______Mother _____Father

Household Income provided by: _____Mother ______Father ___Other family members _____SSI _____Other

What level of education do you hope your child will complete? _________________________________.

Place a check next to any illness or condition that any member of the immediate family has had. When you check an item, please note the member's relationship to the child.

Illness/Condition	Y or N	Family Member Name/Relationship to Child	Past Issues or Current Issues?	Seeking Professional Services? Y or N	Type of Illness/Condition	
Alcoholism/Substance Abuse						
Cancer						
Genetic Disease/Condition						
Diabetes						
Sickle Cell Anemia						
Kidney Problems						
Thyroid Problems						
Seizures						
Serious Illness						
Debilitating injuries/disabilities						
Heart Trouble						
Nervous/Psychological Problems						
Psychiatric Problems						
Depression						
Anxiety						
Physical/Sexual Abuse						
Emotional Abuse/Neglect						
Suicide Attempt						
Suicide Completion						
Other						

Please check any past, present, or impending special problems in your family:

Issues	Y or N	Family Member Name/Relationship to Child	Past Issues or Current Issues?	Seeking Professional Services? Y or N	Type of Illness/Condition	Other Comments
Divorce						
Gaming						
Gambling						
Legal Problems						
Frequent Relocations						
Financial Crisis						
School Problems						
Learning Problems						
Attention Problems						
Truancy						
Deaths						
New Children						
Marital Strifes						
Other						

Do you (parents or child) smoke? Y/N If yes, do you smoke in the household? Y/N

PLEASE ANSWER FOR BOTH CAREGIVERS IN THIS SECTION
CAREGIVER 1: (indicate who you are)____

Have you personally experienced significant family abuse?_______________________________________

Have you personally experienced legal problems?____

Did you experience learning problems in school?____

In general, how happy or adjusted were you growing up?_______________________________________

How much is your immediate family a source of emotional support for you?____________________________

Who in your family do you feel closest to? __________________________________

Most distant from? __________________________In most conflict with?_____________________________

Social History: ____

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CAREGIVER 2: (indicate who you are)____

Have you personally experienced significant family abuse?______________________________________

Have you personally experienced legal problems?____

Did you experience learning problems in school?____

In general, how happy or adjusted were you growing up?_______________________________________

How much is your immediate family a source of emotional support for you?__________________________

Who in your family do you feel closest to? __________________________________

Most distant from? _________________________In most conflict with?_____________________________

Social History:____

EDUCATIONAL HISTORY

Has your child had any academic, behavioral, or problems in school?

Problem	**Type**	**Severity Level (1 to 5)**	**Comments**
Academic			
Behavioral			
Peer Related			
Retention (repeated Grades)			

How did your child perform academically/socially in each grade? (poor/fair/good/excellent):

	Academically	Socially
Daycare/Preschool/Headstart		
Elementary School		
Middle School		
High School		

Has your child ever been expelled/ suspended? (Y/N)____

Has your child ever been tested? (Y/N): ____

Does your child have an IEP (individualized education plan)? (Y/N)

SOCIAL

Does your child have many friends (In/Out of School)? Who are they? ______________________________
____
____

Does your child have difficulty making or keeping friends? ______________________________
____
____

What is your child's style like when making friends? Do you think his/her style is effective or not?
____
____
____.

Based on your child's style - Whose perception is this based on – yours (the parent), the teacher's (feedback/parent-teacher meetings), or both?
____
____
____
____.

Has your child been tested for learning disabilities? Special Education/Support Services?
____
____
____

Please check where appropriate:
______ Has difficulty with reading ______ Has difficulty with math
______ Has difficulty with spelling ______ Has difficulty with writing
______ Other subjects: ______________________________
______ Does not like school

PSYCHIATRIC HISTORY
Place a circle for each symptom that applies to your child (please make a note next to each item that you circle an explanation, the duration, and treatment history if any) :

Symptom	Y/N	Frequency	Intensity	Duration	List with Details
Fears					
Sadness					
Anger					
Irritation					
Explosive Outbursts					
Gets Upset Easily					
Cruel to Animals					
Sets Fires					

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Symptom	Y/N	Frequency	Intensity	Duration	List with Details
Breaks Things Belonging to Himself					
Breaks things Belonging to Others					
Decreased Energy					
Increased Energy					
Loss in Interest in Activities					
Increased Interest in Danger					
Risk Taking					
Oversleep					
Cannot go to Sleep					
Nightmares					
Night Terrors					
Frequent Awakenings					
Decreased Appetite					
Increased Appetite					
Overeating					
Binging					
Forced Vomiting					
Use of laxatives					
Smokes					
Uses/Abuse Drugs					
Self-Harm					
Performs Rituals					
Sees Things That Are Not There					
Obsessive Concerns					
Worries					
Hears Things That People Do Not					
Repeats Specific					

Symptom	**Y/N**	**Frequency**	**Intensity**	**Duration**	**List with Details**
Repeats Behaviors Over and Over Again					
Suicidal Thoughts					
Homicidal Thoughts					
Depression					
Anxiety					
Dependent					
Concerns with Physical Problems					
Rapid Mood Changes					
Worthlessness					
Hopeless					
Poor Self-Esteem					
Stomach Aches					
Shy					
Withdrawn					
Wets Bed/Clothes					
Swears/Curses					
Fidgety					
Impulsive					
Hyperactive					
Steals					
Runs Away					
Can't Wait Turn					
Doesn't Share					
Doesn't Listen/Doesn't Follows Instructions					
Forgets					
Harms Self					
Harms Others					
Speech Difficulties					
Hearing Difficulties					
Language Difficulties					

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Symptom	Y/N	Frequency	Intensity	Duration	List with Details
Vision Difficulties					
Rocks Back and Forth					
Tantrums					
Bangs Head					
Bites Nails					
Pulls Hair/Eye Lashes					
Sucks Thumb/Fingers					
Overly Neat					
Perfectionism					

CHILD'S DEVELOPMENTAL HISTORY

Prenatal events: ____

Parents' attitude toward pregnancy ____

Conception – ease ______planned _______unplanned _________________

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc.____

Birth and Postnatal period:

Birth weight _____Length _____Labor duration _______Delivery: vaginal ____C section _____Problems ______

APGAR scores (if known) ___________ Any jaundice? Yes ______ No ______ Time in hospital _____________

Complications?____

Mother's health after delivery ____

Post Partum Depression? ______if yes, how long? __________________

Primary caretaker for child, first year____
thereafter ____

Feeding history: Age breastfeeding was weaned _____Age bottle feeding was weaned _____

Food allergies ____

Separations from mother and/or father: age, duration, reaction to: ___________________________________
____

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Toilet training:
Age reached bowel control: day _______night _______
bladder control: day _______night ______
Toilet trainings methods used _____________________ease __________current function: Good/adequate/poor

Sexual development: Gender identity issues (Y/N): ____

Motor development: (please write in age, parentheses are approximate normal limits)

rolls over (3-5m)________sit without support (5-7m)________crawls (5-8)________walks well (11-16m)________

runs well (2y)_______________rides tricycle (3y)_________________throws ball overhand (4y)________________

current level of activity ____

fine and gross motor coordination _______________________compared to peers ____________________________

Language development: (please write in age, parentheses are approximate normal limits)

several words besides dada, mama (1y)________________name several objects-ball, cup (15m)________________

3 words together--subject, verb, object (24m) _____vocabulary ______articulation _____comprehension ______

compared to peers ____

any current problems ____

Social development: (please write in age, parentheses are approximate normal limits) smile (2m) ___________

shy with strangers (6-10m) ____separates from mother easily (2-3y) ____cooperative play with others (4y) ____

quality of attachment to mother_______________________quality of attachment to father_____________________

relationships to family members ____
early peer interactions ____

current peer interactions ____

special interests/hobbies____

Behavioral/Discipline: compliance vs. non-compliance ____

lying/stealing ________________rule breaking _________________methods of discipline ___________________

other problems ____

Emotional development: early temperament ____

current personality ____

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mood ____________________________________fears/phobias _______________________________________

habits ____

special objects (blankets, dolls, etc.) ______________________ability to express of feelings ________________

Drug/Alcohol History: ____
____

School History: current grade _______________school contact _______________________________________

number of schools attended _________________ average grades _______________________________________

homework problems ____

specific learning disabilities ____

strengths ____

what have teachers said about the child/teen ____
____

Please bring school report cards and any state, national or special testing that has been performed.

Overall Strengths & Challenges -- as viewed by parents

____
____
____
____

Overall Strengths & Challenges-- as viewed by the child/teen

____
____
____
____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes _____ No ______
If yes, what kind?____
During pregnancy, did mother smoke? Yes ______ No ______
If yes, how many cigarettes each day? ____
During pregnancy, did mother drink alcoholic beverages? Yes _____ No ______
If yes, what did she drink and how often? ______________________________________
During pregnancy, did mother use drugs? Yes _____ No _______
If yes, what kind and how often?____
Were forceps used during delivery? Yes _______ No ___________
Was a Caesarean section performed? Yes _____ No _________
If yes, for what reason? ____
Was the child premature? ____
If so, by how many months? _________________________

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What was the child's birth weight? ____________________
Were there any birth defects or complications? __________________________
If yes, please describe: ____
Were there any feeding problems? Yes ______ No ______
If yes, please describe: ____
Were there any sleeping problems? Yes ______ No ________
If yes, please describe: ___________________
As an infant was the child uiet? _________________________Yes _____ No ______
As an infant, did the child like to be held? Yes ______ No ______
As an infant, was the child alert? Yes ______ No _______
Were there any special problems in the growth and development of the child during the first few years? Yes _____ No _______
If yes, please describe: ____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a questions mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	*Age*	*Behavior*	*Age*
Showed response to mother	______	Put several words together	______
Rolled over	______	Dressed self	______
Sat alone	______	Became toilet trained	______
Crawled	______	Stayed dry at night	______
Walked alone	______	Fed self	______
Babbled	______	Rode tricycle	______
Spoke first word	______		

Early Childhood

Child walked:	Child spoke words:	Child spoke sentence:
______< 12 months	______ < 12 months	______ < 12 months
______ 12 – 24 months	______ 12-24 months	______ 12-24 months
______ 24-36 months	______ 24-36 months	______ 24-36 months
______ > months	______ > months	______ > months
______ has never walked	______ has never spoken words	______ has never spoken sentences

	Circle all	that apply:							
Infancy	Easy	Friendly	Easy going	Regular sleep patterns	Difficult	Slow to warm up	Fussy	Unpredict able sleep patterns	
Toddlerhood	Active	Adventuresome	Can focus attention	Moody	Outgoing	Passive	Clingy	Distracted	Cheerful
Preschool	Separated Easily	Got Along with Peers	Got Along with Adults	Difficulty Separating	Problems with Peers	Behavior Problems			
Latency	Got Along with Peers	Problems with Peers	School Behavior Problems	Got Along with Adults	Poor Relationship with Teacher/Adults	Performs Well at School			
Adolescence	Got Along with Peers	School Behavior Problems	Gets Along with Teacher/Adults	Problems with Peers	Performs Well at School	Poor Relationship with Teacher/Ad ults	Has Several Friends		

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from *BASC*
Revised by Erin M. Dugan, PH.D., LPC-S, RPT/S 2009; Revised by Erin M. Dugan, PH.D., LPC-S, RPT/S 2012, 2016

Puberty

Onset of puberty (breast development, menstruation, pubic hair, facial hair):

______ < 10 years ______ 14-16 years
______ 10-12 years ______ > 16 years
______ 12-14 years ______ no development

MEDICAL HISTORY

Medical Illness	Y/N	Details
Seizures		
Head Injury		
Blurred Vision		
Thyroid Problems		
Dizziness		
Eye Problems		
Kidney Problems		
Allergies		
Hearing Problem		
Blood Transfusion		
High Fever		
Pregnancy		
Asthma		
Diabetes		
Heart Problems		
Hospitalizations/Surgeries		
Serious Illness		
Loss of Consciousness		
Digestive Problems		
Blood in Urine		
STD		

Other:
____
____.

Present Medications: ____

Type:_________________________ Type: _______________________
Dose: _______________________ Dose: _______________________
Frequency: ___________________ Frequency: ________________________

Pediatrician Name: ______________________________ Contact #: _____________________________

LEGAL HISTORY

Physical Abuse (Y/N) Describe:____
____
Date of Report: ____

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Sexual Abuse (Y/N) Describe: ____

____

Date of Report: ____

Sexual Abuse (Y/N) Describe:____

____

Date of Report: ____

Neglect (Y/N) Describe: ____

____

Date of Report: ____

Was a Forensic Examintion/Interview Taken? Yes ______ No ______ Date: ____________________
Interviewer ___________________________________ Phone: ________________________
Impending Court Appearance: Yes ______ No ______ Date: _______________________
Purpose: ____

Domestic Violence Shelter? Yes ______ No _______ Describe: ____________________

____

Caseworker ______________________________ Phone: ____________________________
Orders of Protection: Yes ______ No ______ Describe: ____________________________

____

Law Enforcement System (For all persons mentioned be as specific as possible about relationship to child)

Contact(s) NOT Leading to Arrest: Yes ______ No ______ Describe: ______________

____

Arrest(s) NOT Leading to Arrest: Yes ______ No ______ Describe: _______________

____

Juvenile Offender System (For all persons mentioned be as specific as possible about relationship to child)
Arrests for Statutory Violation(s): Yes ______ No ______ Description/Outcome _______

____

Arrests for Misdemeanor(s): Yes ______ No ______ Description/Outcome ___________

____

OTHER INFORMATION

What are your child's favorite activities?
1. _______________________2. _________________________ 3. ________________
4. _______________________5. _________________________ 6. ________________

What activities would your child like to engage in more often than he/she does at present?
1. ____________________ 2. ______________________ 3. ____________________

What activities does your child like least?
1. ____________________ 2. ______________________3. _____________________
Has your child ever been in trouble with the law? Yes ______ No _______
If yes, describe: ____

____

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CAREGIVER'S EXPECTATIONS OF SERVICES:

What do you expect from receiving services for your child? For yourself? Explain.

____
____
____.

What are your goals for your child? For yourself? Explain.

____
____
____.

How long do you believe the therapy should take for your child's presenting issue(s) to be resolved? Explain.

____
____
____.

What is your role as your child's caregiver(s)? Please describe for both caregivers.

____
____
____.

What stressors are evident in your lives?

____
____
____.

What do you believe the role of the therapist is who will be providing services to your child?

____
____
____.

Is there any other information that you think may help us in working with your child?

____
____
____

LSUHSC Occupational Therapy Clinic

Policy & Procedures

Please read the following statements carefully and sign below. Please direct any questions to Lee Barton (Occupational Therapy Department Coordinator) throughout your therapy process. These helpful procedures are intended to protect the therapeutic environment and maximize the quality of your therapy experience. Thank you for your cooperation.

1. Do be on time for all appointments. (Arriving 10-15 minutes early is recommended to ensure timely service).
2. Do check in with Lee Barton or before you begin your clinic session.
3. Please schedule and change appointments with Lee by calling 504-568-4302 or by emailing otclinic@lsuhsc.edu to ensure that appointments are set to fit your schedule. Check the TAVOCA appointment reminder system to confirm or cancel sessions.
4. Please do not leave children unattended.
5. Please pay for sessions and submit co-pays etc. with Lee in the OT department office.
6. Do be aware of our missed session policy: if you miss 2 or more sessions or fail to show up for 2 or more scheduled sessions without providing 24-hour notice, your remaining appointment times will be removed from the schedule and you will have to contact the LSUHSC Occupational Therapy Clinic to arrange for a new appointment times.
7. If you need to cancel a session after clinic hours, please leave a message on the voicemail system or through the TAVOCA system.
8. To ensure proper training of all student therapists, please consent to the observation of clinic interns of your therapy session.

   I approve observations of my therapy sessions ~ Initial here _____________.

   I do NOT approve observations of my therapy sessions ~ Initial here ____________.

____

Print Name

__________________________________ _________________

Signature Date

LSU Health NEW ORLEANS

OCCUPATIONAL THERAPY EVALUATION

Name of Patient:
DOB: 07/
Date of Evaluation:
Physician:
Dx:

Onset:
Age:
Sex:
UE Dominance:

History of present illness:

Presentation:

Past Medical History:

Social History:

Living Situation:
[ ] House
[ ] Apt/Condo
[ ]Homeless/Shelter
[ ] Group Home
[ ] Steps
[ ] Handrails
[ ] Elevator
[ ] Ramp
[ ] W/C Accessible

Vocational/Household Responsibilities
[ ] Cooking
[ ] Cleaning
[ ] Washing Clothes
[ ] Mowing Yard
[ ] Paying Bills
[ ] Grocery Shopping
[ ] Care of Others
[ ] Care of Pet(s)

Lives With:
[ ] Spouse
[ ] Parents
[ ] Children
[ ] Unrelated Adult
[ ] Alone

Self-Care:
[ ] Independent.
[ ] Assisted
[ ] Dependent
[ ] Equipment

Patient Goals:

Pain Management:

Sensorimotor:

Touch/Perception/Visual			
	Intact	**Impaired**	**Absent**
Light Touch			
Sharp/Dull			
Temperature			
Prorioception			
Kinesthesia			
Stereognosis			
Spatial Neglect			
Motor Planning			
Visual Fields			

Upper Extremity Range of Motion

Put a check if client is Within Functional Limits, “X’ if client is not WFL, and N/A if PROM not tested

AROM	PROM		AROM	PROM
		Shoulder Extension		
		Shoulder Flexion		
		Shoulder Abduction		
		Shoulder Adduction		
		Shoulder External Rotation		
		Shoulder Internal Rotation		
		Elbow Extension		
		Elbow Flexion		
		Forearm Supination		
		Forearm Pronation		
		Wrist Extension		
		Wrist Flexion		
		Wrist Ulnar Deviation		
		Wrist Radial Deviation		

Limitations present:

____

____

____

____

____

Grip/Pinch

Left					Right			
#1	#2	#3	**AVERAGE**		#1	#2	#3	**AVERAGE**
				Grip				
				Lateral Pinch				
				Tip Pinch				
				3 point Pinch				

Neuromuscular:

Activities of Daily Living:

Cognition:

Psychosocial:

Assessment:

Goals:
By discharge, patient will:

Intervention Plan:

Therapist Name LA OT License # Date

Account # : 11600

Authorization # :________________________
G Code:______________ C Code______________
Anticipated:
G Code:______________ C Code______________

Department of Occupational Therapy Clinic

School of Allied Health Professtions
Department of Occupational Therapy
1900 Gravier St. 8th Floor
New Orleans, LA 70112-2262
Phone: 504.568.4302
Fax: 504.568.4306

Date of Service: / / 2019

Patient Name : LAST FIRST

REFERRING PHYSICIAN:

ICD-10-CM CODE	**DESCRIPTION**	**DIAGNOSIS**
__________	____________________	PRIMARY
__________	____________________	SECONDARY

QTY	***CPT***	***DESCRIPTION***
	97165	Occupational Therapy Evaluation, Low complexity
	97166	Occupational Therapy Evaluation, Moderate complexity
	97167	Occupational Therapy Evaluation, High complexity
	97168	Occupational Therapy Re-evaluation
	97010	Supervised Hot or Cold Pack
	97014	Electrical Stimulation (unattended)
	97018	Supervised Parrafin
	97110	Therapeutic Exercises, each 15 min.
	97112	Neuromuscular Re-education, 15 min.
	97124	Massage
	97530	Therapeutic Activity, Direct
	97150	Therapeutic Procedures, Group
	97535	Self-Care, ADL, or Home Management Training, 15 min.
	97533	Sensory Integration, 15 min.
	97532	Cognitive Skill Training, 15 min.
	97537	Community/Work Reintegration, 15 min.
	97760	Orthotic Fitting and Training, 15 min.
	97762	Orthotic/Prosthetic Check, 15 min.
	97761	Prosthetic Training, 15 min.

I certify that: 1) All services on this form were rendered and are hereby approved for billing, 2) the medical record for this date has been documented for the note services, and 3) the rendering of the services and the documentation in the medical record are in accordance with LSU HSC guidelines.

PROVIDER'S SIGNATURE:

____

LSU Health NEW ORLEANS

PROGRESS NOTE

Name of Patient:
DOB:
Date of Initial Evaluation:
Physician:
Dx:

Date of session:
Onset:
Age:
Sex:
UE Dominance:

Subjective:

Objective:

Assessment:

Plan:

Therapist Name	LA OT License #	Date

PATIENT ADMISSION FORM

Account number: ______________________________ Appointment Date: _______________________

Chart Number: ________________________________ Physical Therapist: _________________________________

Referring Physician: _______________________________ Phone #: ________- _________-________

Referring Physician NPI#: _____________________________ Fax #: ________ - _________ - _________

For Office Use Only

DATE _______________

HOME PHONE # _____________________ CELL PHONE # ___________________ OTHER PHONE # _____________

NAME ____ SOCIAL SECURITY # ______________________________

MAILING ADDRESS ___________________________ CITY __________________ STATE ________ZIP ___________

BIRTH DATE _______________________ AGE _________ STATUS (circle one): S M W D SEX (circle one) M F

SPOUSE'S NAME ______________________________ SPOUSE'S S.S.# ____________________ D.O.B.__________

MAJOR COMPLAINT/DIAGNOSIS ____

DATE OF ACCIDENT/INJURY _________________________ TYPE (circle one): WORKER'S COMP AUTO OTHER

EMERGENCY CONTACT ___________________________________ PHONE # ______________________________

EMPLOYER NAME____

EMPLOYER ADDRESS ____

EMPLOYER PHONE _______________________________________

NEXT DOCTOR'S APPOINTMENT (date) __________________________________

PRIMARY INSURANCE ____ POLICY ID # _________________________

POLICY HOLDER ____ POLICY HOLDER S.S.# _____________________

SECONDARY INSURANCE ____ POLICY ID # _________________________

POLICY HOLDER ____ POLICY HOLDER S.S.# _____________________

Have you received any physical therapy services this year? (circle one) Y N If yes, how many visits? _______________
Who is responsible for this bill? ____
Will you be paying by (circle one) CASH CHECK CREDIT CARD

I acknowledge the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of treatment. I irrevocably assign all benefits to LSU-HSC Physical Therapy Clinic. I authorize release of medical records to my doctor and insurance company. If my reason for seeking treatment is the result of a work-related or personal injury claim, I also release information to my attorney, claims adjustor and my employer. I also authorize any physician or medical facility to release information relevant to LSU-HSC Physical Therapy Clinic. I understand and agree that (regarding my insurance status), I am ultimately responsible for the balance of my account for any professional services.

PATIENT'S SIGNATURE: ____ DATE _______________________

LSUHSC Physical Therapy Clinic

Name: ___________________________ SSN: _____________________ Date: _______________

Leisure Activities, including exercise routines: ____

Occupation, including activities that comprise your workday: ____

Age: ________ Height: ____________ Weight: ____________

Are you on a work restriction from your doctor? ☐ Yes ☐ No Are you latex sensitive? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

ALLERGIES: List any medication(s) you are allergic to: ____

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Weight loss/gain
- ☐ Muscle weakness
- ☐ Falls
- ☐ Difficulty maintaining balance while walking
- ☐ Numbness or tingling
- ☐ Dizziness/lightheadedness
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Changes in bowel or bladder function
- ☐ Constipation
- ☐ Diarrhea
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cough
- ☐ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Bone or joint function
- ☐ Depression
- ☐ Chemical dependency(i.e. alcoholism)
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Rheumatoid arthritis
- ☐ Other arthritic condition
- ☐ Bladder/urinary tract infection
- ☐ Kidney problem/infection
- ☐ Sexually transmitted disease/HIV
- ☐ Pelvic inflammatory disease
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Eye problem/infection
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ depression
- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Blood clots

During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Is this something with which you would like help? ☐ Yes ☐ Yes, but not today ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ________________________ 2.________________________ 3.________________________

4.________________________ 5.________________________ 6.________________________

Have you ever taken steroid medications for any medical conditions? ☐ Yes ☐ No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1.________________________ 2.________________________ 3.________________________

LSUHSC Physical Therapy Clinic

What date (roughly) did your present symptoms start? ____

What do you think caused the symptoms? ____

My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc.): __________________________________

Please list special tests performed for this problem (x-ray, MRI, labs, etc.): ________________________________

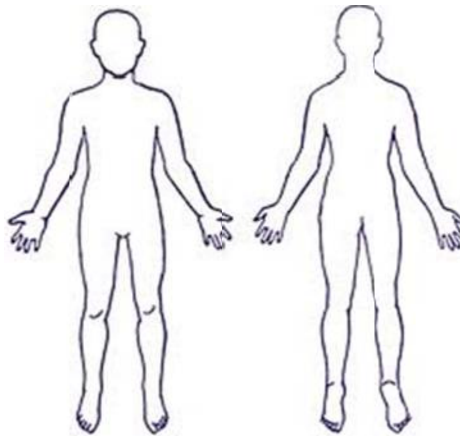
Have you ever had this problem before: ☐ Yes ☐ No When: ______ Treatment received: _______________

How long did it take for you to feel better? ____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ Shooting/sharp pain
O Dull/aching pain
‖ Numbness
= Tingling



Draft

My symptoms currently: ☐ Come and g ☐ Are constant ☐ Are consta t, but chang with activit

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1.____

2.____

3.____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1.____

2.____

3.____

How are you currently able to sleep at night due to your symptoms?
☐ No problen sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise
When are your symptoms best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

Using the 0 to 10 scale, with 0 being “no pain” and 10 being “worst pain imaginable” please describe:

Your current level of pain while completing this survey: _________
The best your pain has been during the past 24 hours: ___________
The worst your pain has been during the past 24 hours: __________

The Dizziness Handicap Inventory (DHI)

P1. Does looking up increase your problem?	o Yes o Sometimes o No
E2. Because of your problem, do you feel frustrated?	o Yes o Sometimes o No
F3. Because of your problem, do you restrict your travel for business or recreation?	o Yes o Sometimes o No
P4. Does walking down the aisle of a supermarket increase your problems?	o Yes o Sometimes o No
F5. Because of your problem, do you have difficulty getting into or out of bed?	o Yes o Sometimes o No
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	o Yes o Sometimes o No
F7. Because of your problem, do you have difficulty reading?	o Yes o Sometimes o No
P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	o Yes o Sometimes o No
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	o Yes o Sometimes o No
E10. Because of your problem have you been embarrassed in front of others?	o Yes o Sometimes o No
P11. Do quick movements of your head increase your problem?	o Yes o Sometimes o No
F12. Because of your problem, do you avoid heights?	o Yes o Sometimes o No
P13. Does turning over in bed increase your problem?	o Yes o Sometimes o No
F14. Because of your problem, is it difficult for you to do strenuous homework or yard work?	o Yes o Sometimes o No
E15. Because of your problem, are you afraid people may think you are intoxicated?	o Yes o Sometimes o No
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	o Yes o Sometimes o No
P17. Does walking down a sidewalk increase your problem?	o Yes o Sometimes o No
E18.Because of your problem, is it difficult for you to concentrate	o Yes o Sometimes o No
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	o Yes o Sometimes o No

E20. Because of your problem, are you afraid to stay home alone?	o Yes o Sometimes o No
E21. Because of your problem, do you feel handicapped?	o Yes o Sometimes o No
E22. Has the problem placed stress on your relationships with members of your family or friends?	o Yes o Sometimes o No
E23. Because of your problem, are you depressed?	o Yes o Sometimes o No
F24. Does your problem interfere with your job or household responsibilities?	o Yes o Sometimes o No
P25. Does bending over increase your problem?	o Yes o Sometimes o No

DHI Scoring Instructions

The patient is asked to answer each question as it pe,1ains to dizziness or unsteadiness problems, specifically considering their condition during the last month. Questions are designed to incorporate functional (F), physical (P), and emotional (E) impacts on: disability.

To each item, the following scores can be assigned: No=0 Sometimes=2 Yes=4

Scoring Key:

>10 points should be referred to balance specialists for further evaluation.

16-34 Points (mild handicap)

36-52 Points (moderate handicap)

54+ Points (severe handicap)

Used with permission from GP Jacobson.

Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. *Arch Otolaryngol Head Neck Surg* 1990;116: 424-427

The Activities-specific Balance Confidence (ABC) Scale*

<u>Instructions to Participants:</u> For each of the following activities, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100% If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports. If you have any questions about answering any of these items, please ask the administrator.

0% 10 20 30 40 50 60 70 80 90 100%

No Confidence Completely Confident

How confident are you that you will <u>not</u> lose your balance or become unsteady when you…

1. …walk around the house? _____%
2. …walk up or down stairs? _____%
3. …bend over and pick up a slipper from the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tip toes and reach for something above your head? _____%
6. …stand on a chair and reach for something? _____%
7. …sweep the floor? _____%
8. …walk outside the house to a car parked in the driveway? _____%
9. …get into or out of a car? _____%
10. …walk across a parking lot to the mall? _____%
11. …walk up or down a ramp? _____%
12. …walk in a crowded mall where people rapidly walk past you? _____%
13. …are bumped into by people as you walk through the mall? _____%
14. …step onto or off of an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. …walk outside on icy sidewalks? _____%

*Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1):M28-34.

Total ABC Score: __________

Scoring: _____________ / 16 = __________% of self confidence

Total ABC Score

P01Jtivo and Negative Affect Scale (PANAS)

This scale consists of a number of words that describe different f�e!ings and emotions. Read each item and then mal'k the appropriate answer in the space next to that word, Indicate to what extent you feel tis way right now, that is, *at* the present moment. Use the following scale to record your answers:

1	Z	3	4	5
ve1y slightly er not at all	a little	moderately	quite a bit	extremely

___ interested
___ distressed
___ excited
___ upset
_strong
___ guilty
___ scared
___ hostile
___ enthusiasic
_._proud
___ irritable
___ alert
_a�hamed
_inspired
___ nervous
___ detennined
___ attentive
_jitte1y
___ active
___ afraid

LSU Health Sciences Center

Speech-Language-Hearing Clinic*Department of Communication Disorders*School of Allied Health Professions*1900 Gravier Street 9th Floor*New Orleans, La 70112*504-568-4337

ADULT CASE HISTORY FORM

BACKGROUND INFORMATION

Patient's Name ____

Address ____

Home Phone Number ________________ Work No. ____________ Cell No. ____________

Birthdate ____________ Age ________ Sex ________ Marital Status ____________

Social Security No. ________ ________ ________ Medicaid/Medicare No. ____________________

Referred by ______________________ Address ______________________

FINANCIALLY RESPONSIBLE PARTY

Name ______________________ Relationship to Patient ________________

Address ____

Employer ______________________ Occupation ________________

MEDICAL INSURANCE

Name ______________________ Phone Number ________________

Contract No. ______________________ Group No. ________________

Name ______________________ Group No. ________________

Name ______________________ Group No. ________________

FAMILY INFORMATION

Patient's Occupation ______________________ Patient's Birthplace ________________

Place of Employment ____

Spouse's Name ______________________ Spouse's Age ________

Occupation ________________ Place of Employment ______________________

List all of the patient's children:

Name	Sex	Age	Any Problems

Who lives in the patient's home:____

Is English the primary language spoken in the home? _____________Other languages spoken in the home _________________

____

Indicate the first language learned, if not English____

HISTORY OF SPEECH PROBLEM

What has the patient been told is his/her main problem or medical diagnosis?____

____

Age of onset: _________Conditions of Onset? ____

Have any attempts been made to treat this problem? _____If yes, list date of treatment, site of treatment, and results of treatment,

reasons for discharge. ____

____

____

____

Are the symptoms constant or do they change? ____

When are they better? _______________________________________When are they worse?_____________________________

To the patient, is this problem considered mild, moderate, or severe? ____

Does the speech/hearing problem cause difficulty in day-to-day living (including educational, social, or vocational plans)?

If yes, please explain.____

____

____

Do people have a difficult time understanding the patient when he/she talks to them? Explain. ______________________________

____

____

What is expected from this visit? ____

____

What questions would the patient like answered from this evaluation?____

____

____

____

____

MEDICAL HISTORY
List the patient's personal physician ____

List serious accidents, illnesses, medical conditions, and surgeries:
Problem_________________________Date__________After Effects____________________________

____

____

____

Indicate past (**p**) and current (**c**)illnesses

_____Allergies
_____Chronic Illness
_____Diabetes
_____Excessive colds
_____High fever
_____Meningitis
_____Oral cancer
_____Sore throat
_____Thyroid problems
_____Asthma
_____Concussions
_____Dizziness
_____Headaches
_____Laryngitis
_____Nausea
_____Pneumonia
_____Speech difficulties
_____Tonsillitis
_____Chicken pox
_____Convulsions, Spasms, seizures
_____Earaches
_____Hearing difficulties
_____Measles
_____Noises in the ear
_____Sinus problems
_____Swallowing problems
_____Upper respiratory infections

Please list any other illnesses the patient has had ____
If the patient has had any convulsions, spasms, or seizures, please indicate how many and when the last one occurred.
____

List all of the patient's physical disabilities ____

List the patient's current medications and reason for the reasons for taking them ___________________________

____

Is the patient in good health at this time? If not, explain ____

____

Estimate health of other family members ____

Does the patient currently have a vision problem? ____

DESCRIPTION OF SPEECH PROBLEM (If there are no concerns about speech, skip this section)
Circle any of the following that describes the patient's voice:

Often hoarse
High-pitched
Low-pitched
Very loud
Too soft
Easily tired
Breaks in voice
Normal

Circle any of the following that describes the patient's speech:

Mispronunciations
Hesitant to speak
Stuttering
Fast rate of speech
Slow rates of speech
Normal speech
Speaks with an accent
Breathy

Does the patient experience any of the following? Circle all that apply.

Difficulty understanding others
Difficulty to get others to understand them
Difficulty finding the right word
Difficulty expressing what they want to say
Difficulty swallowing
Difficulty reading and comprehending

Has anyone looked at the patient's vocal cords and/or soft palate? If yes, what did they find? ________________________________

____

____

DESCRIPTION OF HEARING PROBLEM

Does the patient believe he/she has a hearing loss? _________________If yes, was it sudden or gradual loss?__________________

____

Has the patient ever had a hearing test?___________If yes, please list when and the results of the test._________________________

____

Has the patient's hearing changed in the last six months?_______Within the last year?________Within the last two years _______

Does the patient's hearing seem to change from day-to-day? ____

Does the patient experience pain in their ears?__________If yes, please indicate which ear and how often _____________________

____

Have the patient's ears ever drained?_________If yes, indicate which ear and how often____________________________________

____

Has the patient ever been exposed to loud noises? If yes, describe ____

____

Has the patient ever worn a hearing aid?_________If yes, is the hearing aid used now?______________________________________

Does the patient feel like his/her hearing loss interferes with communication? Explain____

____

Does anyone in the family have a hearing loss? ____yes _____no Relationship____

EDUCATIONAL HISTORY

What was the highest level the patient achieved in school?____

Were his/her grades considered good, average, or poor?____

Were any school subjects difficult for the patient?________Specify____

Did the patient have reading difficulty in school?____

SOCIAL HISTORY

Please list any/all as they apply to the patient for the following:

Hobbies ____

Leisure time activities ____

Group memberships____

Does the patient engage in hunting activities?____

Has the patient ever been enlisted in the military?___________If yes, when____

OCCUPATIONAL HISTORY

How long has the patient had his/her current occupation?____

What was his/her previous occupation?____

Is the patient retired?________________If yes, for how long?____

Has the patient's speech/hearing problem caused him/her to change jobs?_____________________________

Explain____

Is the patient's working environment noisy?____

OTHER (past or current)

List other professional services (including psychological, neurological, hearing, speech, etc.) received. Include name and date of service.

____

____

____

Please give any other information you think would be helpful to us in working with the patient.

____

____

____

Name of the person completing this form (if not the patient)_______________________________________

Relationship to patient__________________________

Revised 10/22/ 2014

LSU Health Sciences Center

Speech-Language-Hearing Clinic * Department of Communication Disorders * School of Allied Health Professions * 1900 Gravier Street 9 th Floor * New Orleans, La 70112. 504.568.4348 phone; 504.568.4352 fax

CHILD'S CASE HISTORY FORM

Date: ______________________________

Child's Name ____ Sex ____________________

Birthdate________________________ Age __________

Address ____

City/State Zip Code

Parents Home Phone________________________ Work____________________ Cell______________________

Email address:

FAMILY INFORMATION

Parent's Name ____ DOB__________________________

Birthplace____ Highest Grade Completed in School _________

Occupation and place of employment____

Parent's Name ____ DOB__________________________

Birthplace____ Highest Grade Completed in School _________

Occupation and place of employment____

Referred by _____________________________________ Address___________________________________

FINANCIALLY RESPONSIBLE PARTY

Name ____ Relationship to child______________________

Address ____

Employer ____ Occupation__________________________

MEDICAL INSURANCE

Name____ Phone#______________________

Contract No:____ Group No:______________________________

Name ____ Group No:_______________________________

Medicare/Medicaid No. ____

List all pregnancies in order (include patient and miscarriages)

Name	Sex	Age	Grade in school	Any Problems

If necessary, use an additional sheet of paper for children's names

Birth History

Did mother have any of the following (check all that apply)

□bleeding	□swelling	□high blood pressure	□low blood pressure	□convulsions	□toxemia
□x-rays	□smoking	□excessive weight gain	□excessive weight loss	□diabetes	□ drink alcohol
□asthma	□surgeries	□heart condition	□thyroid condition	□rubella	□accident
□kidney disease	□susbstance abuse	□Other	Add other conditions:		

Was pregnancy normal?______________ Were there any illnesses during pregnancy__________________

Specify

List medications during pregnancy____________ ____

Diet during pregnancy____

Did labor come before or after due date?______________________How early or late?______________________

How long was labor?____________________________Medication during labor?____________________________

Type of delivery____________________________________ What was the patients' birthweight?_____________

Was delivery _____head first ______feet first Did the baby turn _______yellow _______blue

Was the baby sleepy?____

Did the baby have sucking or feeding difficulty?____

Did the baby have birth defects?____

Medical History

What serious illness or accident has the child had? ____

Does your child have any handicaps?____________If yes, describe ____________________________________

____

Indicate the illness the patient has had and the age at the time he/she had them. Check all that apply

□ Measles _________ Age	□ Mumps _________ Age	□Chicken pox _________ Age	□ Frequent Colds_________ Age	□ Allergies _________ Age	□ Speech difficulties _________ Age
□ Serious high fever _________	□Earache or draining ear _________ Age	□ Hearing difficulties _________ Age	□ Asthma _________ Age	□ Bed wetting _________ Age	□ Vomiting or headaches _________ Age
□ Meningitis _________ Age	□ Pneumonia _________ Age	□ Convulsions, spasms or seizures _________ Age	How many convulsions, spasms or seizures? _________	When was the last convulsions, spasms or seizures ________?	

Describe these medical problems
____

What medication is the child taking? ____
What surgery has the child had? ________________________________When?_____________________
Has child had an EEG (Brain wave test)?__________When? ___________Where?____________________
Results____
Is the child in good health at this time?___________Does the child have a visual problem? ____________
Describe____
Health of other family members

____

Developmental History (state age when the child first:)

	Fed self	**Toilet trained**	
Sat alone ________	spoon ________	day______	Rode tricycle _______
Walked alone _______	fork _______	night______	Rode bicycle _________

Speech, Language and Hearing History

List any speech or hearing problems on either side of the family ______________________________
____
What have you been told is your child's main problem or diagnosis?_____________________________
What has been done about it?____
What do you expect of this visit? ____
What questions would you like answered from this evaluation? ________________________________
During the first year did your child make much sound other than crying?__________________________
What age did your child first say words? _______What were they?___________________________
Did your child keep adding words once he started to talk?____________________________________
What age did your child first start to talk?____What age did your child name most things?____________
What age did your child combine words into small sentences like, "Want drink" or "Me cut"?___________
What age did your child use more complete short sentences? __________________________________
Did the speech learning ever seem to stop for a period?__________If so describe ____________________

What efforts have been made to help the child talk better?____________________________________
Has there been a change in your child's speech in the last six months?
Describe the change____
Was his/her speech ever better than it is now? ____
Has there been any change in the child's hearing in the last six months?__________________________
____
Describe the change ____

Has either ear ever pained or ached?____
Is your child's hearing better on some days than others? _____________________________________

How does your child communicate with you? ____

Education

Name of the present school __________________________Address______________________________

Previous schools attended:

Age entered______Grade entered_______ Current grade ______ Teacher (s)______

School performance: ___Good ___Average ___Poor

Have you ever applied for services? ________Are you currently receiving services (if yes, specify)

When ? _______________ Where? ____

Comments____

Social

Who lives in the home with your child? ____

What unusual fears does your child have? ____

How would you describe your child (circle): Leader Follower Active Nervous

Plays well with others Plays alone Shy Aggressive

Describe any behavioral problem(s)

____

____

Is your child	□ Left handed	□ Right handed	□ No hand preference

Other Information

(List name, address and date of services of physicians and/or other agencies)

Physicians or Agency Address Date Seen

____

Please give any other information you think would be helpful to us. _______________________

Name of the person completing this form____

Relationship to the child ____

LSU Health Sciences Center

Speech-Language-Hearing Clinic, Department of Communication Disorders, School of Allied Health Professions, 1900 Gravier Street, 9 th Floor, New Orleans, La 70112

Date: ___________________________

Augmentative and Communication Case History Questionnaire - Adult

Identification

Name: ____Birthdate:_________________Age:______Sex:_______
Address: ____
Home Phone: (_____)_____________Cell Phone 1: (_____)_____________Cell Phone 2:(_____)________________
Parent(s)/Spouse: ____
Address: ____Phone:(_____)________________
Referred by: ____
Address: ____Phone: (_____)_____________________
Reason for referral:____
____
Person(s) completing questionnaire: ____
Address (if different from above): ____________________________________Phone: (_____)_____________________
Relationship to individual: ____

Statement of the Problem

Please describe the communication problem fully. You may continue your description on the back of this sheet if necessary.

____
____
____
____
____
____
____
____
____
____
____
____

What do you expect from this evaluation?

____
____
____

Medical Information

Medical diagnosis (check all that apply and indicate date of onset):

____________________Cerebral Palsy (type______________)
____________________Aphasia
____________________Dysarthria
____________________Apraxia
____________________Amyotrophic lateral sclerosis (ALS)
____________________Seizure disorder
____________________Muscular Dystrophy
____________________Laryngectomy
____________________Cognitive Disorders
____________________Autism
____________________Multiple sclerosis
__________Other (specify)____________________
____

Medical condition: __________Stable __________Progressive

Physician's name:____

Address: ____Phone: (________)________________

Please indicate any medication currently used, the dosage, purpose and prescribing physician (if applicable):

Medication Dosage Purpose Prescribing physician

____

____

____

____

Vision

Does the individual have any visual problems? Yes_________ No__________

If so, please describe:

____

Date of the most recent vision test: ____

Test results: ____

Where tested?________________________________By whom?____________________________

Address: ____

(If the individual has a significant vision problem, please forward us a copy of the examination report.)

Hearing

Does the individual have any difficult hearing? Yes_________ No__________

If so, please describe:

____

Date of the most recent vision test: ____

Test results: ____

Where tested?________________________________By whom?____________________________

Address: ____

(If the individual has a significant hearing problem, please forward us a copy of the examination report.)

Cognitive Information (If applicable)

Has the client had a psychological evaluation prior to this time? ___________

If so, date of most recent evaluation: ____Test results? ____

Where tested? ____

By whom?____

Address: ____

(Please forward us a copy of the most recent evaluation report.)

Motor Ability

Method of mobility (please check all that apply):

_________Walks Unassisted

_________Walks Assisted

_________Stroller

_________Wheelchair

Most reliable movement patterns:

_________Pointing

_________Raising Arm

_________Eye Pointing

_________Other (specify) ______________________

Self-Help Skills

Does the individual:

Feed self? _______ Dress self? _______ Toilet self? _______

If not, does theindividualrequire:

_______Partial assistance _______Complete assistance

Comments: ____

Academics (if applicable)

Highest academic level completed: ____

If the individual still attends school, please provide the following:

Present grade:	___________	Type of class:	___________
Reading level:	___________	Spelling level:	___________
Math level:	___________	Writing proficiency:	___________

Can the individual (check all that apply):

Match objects:	___________	Match colors:	___________
Match shapes:	___________	Match numbers:	___________

School Name: ____

Address: ____Phone: (______)_______________*

Teacher's name: ____

Employment (if applicable)

Present employment status: ____

Employer: ____

Job description: ____

* Please include a copy of the individual's most recent report card. (if applicable)

Environment

Place of residence:

_________Private family dwelling

_________Nursing home

_________Other ______________

_________Group home

Persons at the residence: ____

What percentage of a typical day is the individual at:

_________Home _________Work _________School _________Other

What percentage of a typical day is the individual:

_________In a wheelchair

_________In chair

_________In bed

_________With walker

_________On floor

_________Side lying

_________Other ________________________________

List places the individual frequently visits:

____

List significant people in the individual's life:

____

List significant objects in the individual's life:

____

List significant activities in the individual's life:

____

Adaptive Equipment

Please check all adaptive equipment your individual uses:

_______Hearing Aid

_______Glasses

_______Walker

_______Wheelchair

_______Communication equipment

_______Others (specify) _________________________________

If wheelchair is used, please describe the following:

Make: __________________________________ Model: _________________________________

Motorized: ______________________________ Manual: ________________________________

Insert components: _______________________ Lap Belt: _______________________________

Chest harness: ___________________________ Tray Measurements: ______________________

Activities tray is used for: ____

Communication

Receptive Information:

Does your individual seem to have trouble understanding speech? _______________________________

If so, please describe: ____

____

Please indicate the individual's level of understanding by checking one of the following:

__________Does not understand spoken words
__________Understands single words
__________Understands simple sentences
__________Understand 2 and 3 part commands
__________Understand conversation

(If applicable) Please list all formal receptive language testing that has been conducted and test results (to be filled out by the individual's speech-language pathologist):

Tests Date given Results

____
____
____

Expressive Information:

Does the individual attempt to communicate? ____
Does the individual initiate communication? ____
Who does the individual attempt to communicate with? ____________________________________
Please indicate all means of communication currently used: (If possible, rank order from most to least frequently used; 1 being most frequently used, etc.)

Speech	____________	Eye pointing	____________
Vocalization	____________	Spoken "yes-no"	____________
Manual Signing	____________	Gestural "yes-no"	____________
Bodily Gestures	____________	Communication Device	____________
Facial Expression	____________		

Spoken Communication

If the individual speaks, please check if the speech is:

________Understood by strangers
________Understood by family/friends only
________Difficult for family/friends to understand
________Is never understood by others

What percentage of the individual's speech are you able to understand?

________100% ________75% ________50% ________what%

If the individual is not understood, is he/she:

________Quickly discouraged ________Persistent
________Frustrated ________Apathetic

Has the individual ever spoken better than he/she does now? _________________
How many words are in the individual's average message?

________One word
________Two to three words
________Four to five words
________Five or more words

Unaided Communication (if applicable) – The use of gestures, manual signs...in which the individual does not rely on the use of any external communication equipment.

Please indicate the type of unaided communication systems currently used by checking the following:

______Natural gestures (handshake for <u>no</u>, pointing)
______Signing Exact English
______American Sign Language
______Signed English
______Cued Speech
______Other (please specify) ________________________
______Pantomime
______Amer-Ind Gestural Code
______Sign System
______Finger Spelling

How many signs/gestures are in the individual's average message?

_______One
_______Two to three
_______Four to five
_______Five or more

Approximately how many gestures/manual signs does the individual currently use spontaneously (i.e., on his/her own initiative without cueing) to communicate?† ____

Aided Communication (if applicable) – The use of communication boards, electronic devices…in which the individual relies on the use of some type of communication equipment.
Please describe the type of aided communication system/device currently used:

____

____

How long has the client been using the device described? ____
Please list all communication systems use in the past and check whether the system proved successful or unsuccessful.

<u>System</u>	<u>Successful</u>	<u>Unsuccessful</u>
________________________________	________	__________
________________________________	________	__________
________________________________	________	__________
________________________________	________	__________

How are vocabulary items represented on the individual's present communication board/device? (check all that apply)

______Photographs
______Color pictures
______Line drawings
______Oakland School Pictures
______Core Picture Vocabulary
______Talking pictures
______Touch 'N Talk stickers
_______Picture communication symbols
_______Rebus symbols
_______Pic symbols
_______Picsyms
_______Blissymbols
_______Letters
_______Other (specify) ____________________________

What is the size of the pictures/symbols representing the vocabulary items? (Example: 1 inch square)

____

How many vocabulary items are displayed on the client's device?‡ ____________________________

† Please attach a listing of these gestures/manual signs.

The individual primarily uses these items:

_______Imitatively

_______In response to questions

_______In response to commands (Example: "Show me what you want.")

_______Spontaneously (i.e., on his/her own initiative without cueing)

If using a non-electronic communication aid/device such as a homemade communication board, how many vocabulary elements/symbols are in the client's average message?

________One

________Two to three

________Four to five

________Five or more

If using an electronic communication aid/device with voice output, what is the length of the programmed/recorded message? ____

Therapy History

List all therapy programs/services the individual has been enrolled in:

Type of Therapy	Therapist	Address	Phone	Dates Enrolled

If presently seen for therapy by a speech-language pathologist, please provide information regarding current therapy goals and intervention (to be filled out by the individual's speech-language pathologist).

____

____

____

Support Services

Probable/current communication interventionist:

Name: ____

Address: ____Phone: ___________________

Indicate agencies for possible financial assistance:

______Medicaid ______Medicare

______Private insurance ______Service group

______SSI ______Church group

______Other

‡ Please attach a listing of the vocabulary items displayed in the child's communication aid. Star (*) those items the child is currently using spontaneously.

Additional Information

If there is additional information which you feel will help us to understand the individual and his/her problem better, please describe:

____
____
____
____
____

Please attach a picture of the individual positioned in seating typically used for everyday activities.

Please print name of person completing the case history ______________________________________

Date ____________________

LSU Health Sciences Center

Speech-Language-Hearing Clinic, Department of Communication Disorders, School of Allied Health Professions, 1900 Gravier Street, 9th Floor, New Orleans, La 70112

Date: ________________________

Augmentative and Communication Case History Questionnaire

Identification

Name: ____Birthdate: _________________Age: ______Sex:_______
Address: ____
Home Phone: (_____)_____________Cell Phone 1: (_____)_____________Cell Phone 2:(_____)________________
Parent(s)/Guardian(s): ____
Address (if different from child): ____Phone:(_____)________________
Other children in family:

Name	Age	Grade	Speech-Language-Hearing or Medical Problems
________________________	______	______	____
________________________	______	______	____
________________________	______	______	____
________________________	______	______	____
________________________	______	______	____

Referred by: ____
Address: ____Phone: (_)_________________________
Reason for referral:____
____
Person(s) completing questionnaire: ____
Address (if different from above): ____________________________________Phone: (_____)______________________
Relationship to child: ____

Statement of the Problem

Please describe the communication problem fully. You may continue your description on the back of this sheet if necessary.

____
____
____
____
____
____
____
____
____

What do you expect from this evaluation?

____

____

____

Medical Information

During this pregnancy, did mother experience any unusual illnesses, conditions, or accidents, such as German Measles, Rh incompatibility, false labor, etc.? If so, please describe:

____

____

____

List any medications taken during the pregnancy.

____

Length of pregnancy: ___________Length of labor: _________________Birth weight: _______________

Were there any problems with the delivery, such as breech birth, caesarean, etc.? If so please explain.

____

____

____

Conditions immediately following birth:

Did the infant have trouble starting to breath? __Was the infant blue? __Was the infant jaundiced? ________

Did the infant have sucking and/or swallowing difficulties? _____Feeding problems? _____Seizures? ______

Other problems?____

Check the illnesses which the child has had. Give the child's age and the severity of the illness. Please add other illnesses which the child has had but which are not listed here.

Illness	Age	Mild, Average, or Severe
Measles		
Chicken Pox		
Mumps		
Frequent cases of the flu		
Scarlet Fever		
Croup		
Tonsillitis		
Bronchitis		
Ear Infections		
Allergies		
Seizures		
Whooping cough		
Meningitis		
Encephalitis		
Other (please specify)		

Were any of the illnesses followed by noticeable changes in the child's general behavior or in his/her speech/language? _______
If so, please describe: ____

____

Has the child had any operations or surgeries?_____If so, please describe:

Surgery	Date of surgery	Physician	Hospital

Please indicate any medical diagnosis regarding the child, such as cerebral palsy, seizure disorder, etc.:

____

Type of cerebral palsy (if applicable): ____

Please list any medications the child is taking:

Medication	Dosage	Purpose	Prescribing physician

Developmental Information

When was the client able to hold his/her head alone? ____________________
Is the client currently able to sit alone without support? ____________________
If so, at what age was the child first able to do so? ____________________
Is the child able to pull up to a standing position? ____________________
If so, at what age was the child first able to do so? ____________________
Is the child able to more to desired object/toys that are out of reach? ____________________
If so, how does the child typically do so?
Rolling? ____________
Crawling? ____________
Walking? ____________
If the child walks without assistance, at what age did he/she first do so? ____________________
Does the child fall or lose balance easily? ____________________
Is the child toilet trained? ____________________
If so, at what age did child become toilet trained? ____________________
Child's present weight: ________________ Child's present height: ________________
Does the child prefer his/her right or left hand? ____________________
If the child awkward using his/her hands? ____________________
If so, please describe: ____________________
Does the child have difficulty chewing or swallowing? ____________________
Does he/she drool? ____________________

Vision

Does the child have any visual problems? Yes_________ No__________

If so, please describe:

____

Date of the most recent vision test: ____

Test results: ____

Where tested?________________________________By whom?____________________________

Address: ____

(If the child has a significant vision problem, please forward us a copy of the examination report.)

Hearing

Does the child have any difficult hearing? Yes_________ No__________

If so, please describe:

____

Date of the most recent vision test: ____

Test results: ____

Where tested?________________________________By whom?____________________________

Address: ____

(If the child has a significant hearing problem, please forward us a copy of the examination report.)

Cognitive Information (If applicable)

Does the child demonstrate functional object use, such as play with objects in the way that they are typically used (e.g., holds a toy telephone up to his/her ear, uses a comb for combing hair,…)?

____

If not, please describe the client's play skill by checking those actions he/she typically performs:

Put toys in his/her mouth ________________________

Hits toys on a surface (e.g., table top) ________________________

Shakes toys ________________________

Drops or throws toys on the floor ________________________

Other (specify) ________________________

Has the client had a psychological evaluation prior to this time? ___________

If so, when? ________________________Where tested? ___________________________________

By whom?____

Test results? ____

(Please forward us a copy of the most recent evaluation report.)

Motor Ability

Method of mobility (please check all that apply):

_________Walks Unassisted

_________Walks Assisted

_________Stroller

_________Wheelchair

Most reliable movement patterns:

_________Pointing

_________Raising Arm

_________Eye Pointing

_________Other (specify)

____

Self-Help Skills

Does your child:

Feed self? _______ Dress self? _______ Toilet self? _______

If not, does your child require:

_______Partial assistance _______Complete assistance

Comments: ____

Adaptive Equipment

Please check all adaptive equipment your child uses:

_______Hearing Aid _______Wheelchair

_______Glasses _______Communication equipment

_______Walker _______Others (specify) ___________________________

If wheelchair is used, please describe the following:

Make: ___________________________ Model: ___________________________

Motorized: ________________________ Manual: ___________________________

Insert components: ___________________ Lap Belt: __________________________

Chest harness: _______________________ Tray Measurements: ____________________

Activities tray is used for: ____

Social Information

Does the child currently attend any nursery school or daycare program? __________

Is so, where? ____

Does the child tend to play alone or with other children? ________________________________

How the child get along with other children? _______________ With adults? _______________

What are the child's favorite activities? ____

List the places the child frequently visits:

____

List the significant people in the child's life, including name and relationship:

____

List the significant object in the child's life (toys, blankets, stuffed animals, etc)

____

Communication

Receptive Information:

Does your child seem to have trouble understanding speech? ____________________________

If so, please describe: ____

____

Please indicate the child's level of understanding by checking one of the following:

_________Does not understand spoken words

_________Understands single words

_________Understands simple sentences

_________Understand 2 and 3 part commands

_________Understand conversation

(If applicable) Please list all formal receptive language testing that has been conducted and test results (to be filled out by the child's speech-language pathologist):

Tests Date given Results

____

____

____

Expressive Information:

Does the child attempt to communicate? ____

Does the child initiate communication? ____

Who does the child attempt to communicate with? ____

Please indicate all means of communication currently used: (If possible, rank order from most to least frequently used; 1 being most frequently used, etc.)

Speech	___________	Eye pointing	___________
Vocalization	___________	Spoken "yes-no"	___________
Manual Signing	___________	Gestural "yes-no"	___________
Bodily Gestures	___________	Communication Device	___________
Facial Expression	___________		

Spoken Communication

During the first year, other than crying would you say that the child was a:

_______silent baby? ______a very quiet baby?

______an average noisy baby? ______a very noisy baby?

At what age did the child:

Start to make cooing and babbling sounds? ___________________________

Say his/her first words? ___________________________

Have a name for most everything? ___________________________

Use two word combinations (example "want cookie")? ___________________________

Use more complex short sentences? ___________________________

Did the child say one or two words and then go a long time before saying any new words? ____________

Did speech/language learning ever seem to stop for a period? ______________________________

If so, please describe:

____

Does the child seem to be aware of his/her speech/language difference? ____________________

If so, please describe:

____

If the child speaks, please check if the speech is:

_______Understood by strangers

_______Understood by family/friends only

_______Difficult for family/friends to understand

_______Is never understood by others

What percentage of the child's speech are you able to understand?

_______100% _______75% _______50% _______what%

If the child is not understood, is he/she"

_______Quickly discouraged _______Persistent

_______Frustrated _______Apathetic

Has the child ever spoken better than he/she does now? ________________

How many words are in the child's average message?

_______One word
_______Two to three words
_______Four to five words
_______Five or more words

Unaided Communication (if applicable) – The use of gestures, manual signs...in which the child does not rely on the use of any external communication equipment.

Please indicate the type of unaided communication systems currently used by checking the following:

______Natural gestures (handshake for no, pointing)	______Pantomime
______Signing Exact English	______Amer-Ind Gestural Code
______Duffy's Innovative	______American Sign Language
______Sign System	______Signed English
______Finger Spelling	______Cued Speech
______Other (please specify) ______________________	

How many signs/gestures are in the child's average message?

_______One
_______Two to three
_______Four to five
_______Five or more

Approximately how many gestures/manual signs does the child currently use spontaneously (i.e., on his/her own initiative without cueing) to communicate?[*] ______________________________________

Aided Communication (if applicable) – The use of communication boards, electronic devices…in which the child relies on the use of some type of communication equipment.

Please describe the type of aided communication system/device currently used:

____

____

How long has the client been using the device described? ______________________________________

Please list all communication systems use in the past and check whether the system proved successful or unsuccessful.

System	Successful	Unsuccessful
____	________	__________
____	________	__________
____	________	__________
____	________	__________

How are vocabulary items represented on the child's present communication board/device? (check all that apply)

_____Photographs	______Picture communication symbols
_____Color pictures	______Rebus symbols
_____Line drawings	______Pic symbols
_____Oakland School Pictures	______Picsyms
_____Core Picture Vocabulary	______Blissymbols
_____Talking pictures	______Letters
_____Touch 'N Talk stickers	______Other (specify) ________________________

[*] Please attach a listing of these gestures/manual signs.

What is the size of the pictures/symbols representing the vocabulary items? (Example: 1 inch square)

____

How many vocabulary items are displayed on the client's device?† ____________________

The child primarily uses these items:

- _______Imitatively
- _______In response to questions
- _______In response to commands (Example: "Show me what you want.")
- _______Spontaneously (i.e., on his/her own initiative without cueing)

If using a non-electronic communication aid/device such as a homemade communication board, how many vocabulary elements/symbols are in the client's average message?

- _______One
- _______Two to three
- _______Four to five
- _______Five or more

If using an electronic communication aid/device with voice output, what is the length of the programmed/recorded message? ______________________________

Therapy History

List all therapy programs/services the child has been enrolled in:

Type of Therapy	Therapist	Address	Phone	Dates Enrolled

If presently seen for therapy by a speech-language pathologist, please provide information regarding current therapy goals and intervention (to be filled out by the child's speech-language pathologist).

____

____

____

Support Services

Probable/current communication interventionist:

Name: ____

Address: ______________________________ Phone: ____________________

Indicate agencies for possible financial assistance:

______Medicaid	______Medicare
______Private insurance	______Service group
______SSI	______Church group
______Other	

† Please attach a listing of the vocabulary items displayed in the child's communication aid. Star (*) those items the child is currently using spontaneously.

Additional Information

If there is additional information which you feel will help us to understand the child and his/her problem better, please describe:

____
____
____
____
____

Please attach a picture of the child positioned in seating typically used for everyday activities.

Please print name of person completing the case history ____________________________________
Date ________________________

0 **LSUHealthNewOrleans** **No.**

HEALTH SCIENCES CENTER

School of Allied Health Professions
1900 Gravier Street• New Orleans, LA 70112-2262

20_

Received From

Dollars($

Patient Account#

Check No. Date of Check Cash$

Dept. Doctor

Received By

0 **LSUHealthNewOrleans** **No.**

HEALTH SCIENCES CENTER

School of Allied Health Professions
1900 Gravier Street• New Orleans, LA 70112-2262

20_ _

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20_

Received From

Dollars($

Patient **Account#**

Check No. **Date of Check** **Cash$**

Dept. **Doctor**

Received By

0 **LSUHealthNewOrleans** **No.**

HEALTH SCIENCES CENTER

School of Allied Health Professions
1900 Gravier Street• New Orleans, LA 70112-2262

20_

Received From

Dollars($

Patient Account#

Check No. Date of Check Cash$

Dept. Doctor

Received By

ALLIED HEALTH DAILY DEPOSITS

ROUTING TICKET #..

FOR THE DAY OF ....

<u>SAID TO CONTAIN</u>

CASH ....

CHECKS ....

VISA ....

[illegible] ....

DISCOVER ....

TOTAL ....

<u>RECEIVED & VERIFIED</u>

CASH ....

CHECKS ....

VISA ....

[illegible] ....

DISCOVER ....

TOTAL ....

<u>RECEIPT NUMBERS</u>

______________ ______________

______________ ______________

______________ ______________

______________ ______________

______________ ______________

<u>RECEIPT NUMBERS</u>

______________ ______________

______________ ______________

______________ ______________

______________ ______________

______________ ______________

PREPARED & SUBMITTED BY:

____

CASHIER

RECEIVED & VERIFIED BY:

____

AH BILLING OFFICE

LSUHealthNewOrleans
School of Allied Health Professions

LSUHSC Child and Family Counseling Clinic
411 S. Prieur St.
New Orleans, LA 70112

Patient Name:	______________________	**Provider Name:**	______________
Account:	______________________	**Date of Service:**	______________
Insurance Co:	______________________	**Referring Provider:**	______________
Authorization #:	__________ **Diag#:** __________	**Location:**	______________

Procedures Codes

- ☐ 90791 Intake/Interview Session $180.00
- ☐ 90839 Crisis Psychotherapy $150.00
- ☐ 90840 Add add'l 30 min $100
- ☐ 90832 Individual Psychotherapy 30 min $100
- ☐ 90834 Individual Psychotherapy 45
- ☐ 90837 Individual Psychotherapy 60 minutes$175
- ☐ 90808 Individual Psychotherapy 75--80 min $200
- ☐ 90834 Interactive Psychotherapy 45 min $135
- ☐ 90875 Interactive Complexity $10
- ☐ 90849 Multi--family group treatment $150
- ☐ 90853 Group Psychotherapy 45--50 min $100 (interactive w/play)
- ☐ 90846 Family Psychotherapy 45--50 min $125 (without patient)
- ☐ 90847Family Psychotherapy 45--50 min $135 (with patient)

Additional Services

- ☐ 90887 Training
- ☐ 90889 Report Writing x $125 HR
- ☐ 96101T esting/Evaluation X $175 HR
- ☐ 99070 Court Testimony X $500 HR
- ☐ 99070 Consultation X $125 HR
- ☐ 99199 Missed Session X $100/HR
- ☐ 98966 Telephone Assessment < 10 min
- ☐ 98967 Telephone Assessment 11--20 min
- ☐ 98968 Telephone Assessment 21--30 min
- ☐ 99070 Emails
- ☐ 99070School Observation x $150 HR

Copay	COINSURANCE
Check #	Check Date:
Credit Card	
Cash	______________
Misc	______________
Comment	

Procedure code approved	Visit's used	Visit's remaining
Procedure code approved	Visit's used	Visit's remaining
Procedure code approved	Visit's used	Visit's remaining

I certify that 1) all services on this form were rendered and are hereby approved for billing 2) The medical record has been documented for these services; and 3) The rendering of the services and the documentation in the medical record is in accordance with LSUHSC guidelines.

________________________________ ________________________________
Signature **Date**

Child's Next Session Will Be Scheduled: ______________________________
Schedule a Consultation With: ______________________________________

______ *Same day/time next week*
_____ *Parent*_________________ *(Specify Week of/Date/Time)*
_____ *in 2 weeks same day/time*
_____ *School Contact* _________________________/_________________ *(Specify Contact Name/Week of;Date;Time)*
_____ *Specify Date/Time*:___________________________
_____ *Other Contact:* _______________________/ _____________________ *(Specify Contact Name/Week of;Date;Time)*