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.
Table of Contents

The Role, Scope, and Mission of the Louisiana State University Health Sciences Center in New Orleans ................................................................. 2

Glossary of frequently used terms ........................................................................ 6
SAHP Clinics Policy and Procedure Committee .................................................. 6

Chapter 1 Clinic Overview ..................................................................................... 7
  1.1 Clinician Credentialing and Licensure .............................................................. 8
  1.1.1 Clinician Credentialing ............................................................................ 8
  1.1.2 Clinician List by Specialty ...................................................................... 9
  1.2 Scope of Services Offered ............................................................................ 9
  1.3 Admittance Criteria ................................................................................... 10
  1.4 Referral to another Agency ....................................................................... 12
  1.5 Clinician's Orders ..................................................................................... 12
  1.6 Discharge Criteria ..................................................................................... 14
  1.7 Education of Patient and Family ................................................................. 16
  1.8 Emergency Management of a Patient, Visitor, and/or Employee .......... 17
  1.9 Signature Identification List ...................................................................... 19
  1.10 Patient Confidentiality ............................................................................. 19

Chapter 2 Pre-visit Procedures .......................................................................... 21
  2.1 Patient Scheduling ................................................................................... 21
  2.1.1 Phone requests .................................................................................... 21
  2.1.2 Referral or Screened Patient ............................................................... 22
  2.1.3 Walk-ins ............................................................................................ 22
  2.2 Patient eligibility ...................................................................................... 23
  2.2.1 .......................................................................................................... 23
  2.2.2 .......................................................................................................... 23
  2.3 Referral/Authorization ............................................................................. 23
  2.3.1 .......................................................................................................... 23
  2.3.2 .......................................................................................................... 23
  2.4 Appointment reminder ........................................................................... 23
  2.5 Appointment Cancellation ...................................................................... 24
  2.5.1 .......................................................................................................... 24
  2.5.2 .......................................................................................................... 25
  2.6 Patient No-Show ..................................................................................... 25

Chapter 3 Patient Visit ....................................................................................... 26
  3.1 Check-in .................................................................................................... 26
  3.1.1 Initial Visit .......................................................................................... 26
  3.1.2 Return visit/Therapy session ............................................................... 26
Appendices

Appendix A
1. Bylaws and Regulations of the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College
2. LSU System Permanent Memoranda
3. LSUHSC – New Orleans Chancellor Memoranda
4. Office of Compliance Programs

Appendix B – Patient Forms
B.1 Required Forms
B.2 Additional Clinic Forms
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

Appendix C – Billing Operations Forms
C.1 Receipts
C.2 Daily Deposit Worksheets
C.3 Charge Slips
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:

- **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.)

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 seen 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 measurable 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 Therapy
      i. 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 complaint 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 website. 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 Dean 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/administration/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** ☐

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
</tr>
</thead>
</table>

- **Female** ☐  **Male** ☐

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Marital Status:  □ S □ M □ D</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ / /</td>
<td>- -</td>
<td></td>
</tr>
</tbody>
</table>

Patient’s Street Address
- City
- State
- Zip
- Phone Number

Responsible Person’s Name
- Relationship to Patient

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

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Contract/Certificate #</th>
<th>Policy or Group #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Insurance Company Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Subscriber</th>
<th>Subscriber Name</th>
<th>Subscriber Social Security #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>( )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber’s Employer</th>
<th>Employer’s Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Secondary Insurance

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Contract/Certificate #</th>
<th>Policy or Group #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Insurance Company Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Subscriber</th>
<th>Subscriber Name</th>
<th>Subscriber Social Security #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>( )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber’s Employer</th>
<th>Employer’s Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### For Office Use Only

<table>
<thead>
<tr>
<th>Appointment Date:</th>
<th>Account #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinician:</th>
<th>Referring Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rev. 010117  B.1.1
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: Employer ☐
(Please indicate with a check) 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
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 care for 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 a court order, the law allows you to review that information.

We are required to follow the practices outlined in this notice. We have the right to change this notice and our privacy practices and to give you notice of the change before we make the new practices effective. Any changes made will apply to all of the protected health information we have about you at this time. If we make a change, we will put a notice in our office. We will also give you a copy of the new notice if you ask for it. You can also read about recent changes on the computer at this site: www.hhs.gov.

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 what is wrong with you and 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.

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 patients. In other situations, we may use or disclose your protected health information, to public health authorities. This may occur when there is a potential public health issue.

To create de-identified databases. We may use your medical information for the purpose of removing your protected health information that tells anyone who you are from the 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 is done 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 other non-profit organizations. This is done through intentionally - 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 or similar activities.

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE DISCLOSED: In addition to using your medical information, we may disclose all of it to the following people:

- Law Enforcement Officers.
- Health Oversight Agencies.
- Tissue Donation and Transplant Services.

For our health care operations. To obtain payment.

Appointment

The law requires us to make sure your medical information is kept private. It also requires us to 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 benefit 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 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 where, with your authorization, we may use or disclose your protected health 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 government functions, as allowed by law. Such functions include:

- Military and veteran activities
- National security and intelligence activities
- Proactive services to the President and others
- Medicolegal investigations
- 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 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 as needed for disaster relief purposes.

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 allows 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 associated.

You have the right to tell us how you would like 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 or copy your medical record. If you think that 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 and options.

You have the right to tell us to change medical information. For example, if we think you have the 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 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 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.

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 use and disclosure of your medical information, please call the Office of Compliance Programs at: (504) 568-5135 to speak with either our Compliance Officer or Privacy Officer.

LSUSHC New Orleans Office of Compliance Programs 434 Franklin Street, Room 3177 New Orleans, LA 70112

Or email: noccompliance@lsuhsc.edu

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

B.1.3
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

B.1.4.
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:** ____________________________

Revised 11/2/2015

B.2.2
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  B.2.3
Authorization for Release of Protected Health Information

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
- History and physical exam
- Laboratory test results
- Photographs, videotapes
- Other, (specify)
- Diagnosis & treatment codes
- Consultation reports
- X-ray reports
- Complete billing record
- Itemized bill
- Discharge summary
- Progress notes
- X-ray films / images
- Psychotherapy Notes

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: ___________________________
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
B.2.5
# Daily Clinic Sign In Sheet

<table>
<thead>
<tr>
<th>Please Sign In</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name (Please Print)</td>
<td>Patient Name (Please Print)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B.2.6
<table>
<thead>
<tr>
<th>Item</th>
<th>Completed (Yes/No)</th>
<th>Notes</th>
<th>Verified By (initials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient registration form</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Consent to Treat</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notice of Privacy Practices</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AV recording form</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization to release medical records form</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of insurance card</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of picture ID</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance verification</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient history</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signed clinic note by billing clinician</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed charge ticket submitted</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient sign-in verified</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS claim form (hearing aids only)</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chart Review completed by: ___________________________ Date: ________________

Revised 11/4/15

B.2.7
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: _______
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.

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

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? %

© Neuromonics  Document No.: I 00179  Revision: 6  Publication Date: 26 May 2010
Tinnitus History Questionnaire

Name______________________________________

DOB: _____ Date Completed: ________________

Nature of the Tinnitus

How does the tinnitus sound?

<table>
<thead>
<tr>
<th>Usual site of the tinnitus? (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left = Right</td>
</tr>
</tbody>
</table>

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?

---

© Neuromonics

Page 1 of 3

Document No.: 1 00178 Revision: 2
# Tinnitus History Questionnaire

**Name**

**Date Completed**

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

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

## General Hearing Problems

<table>
<thead>
<tr>
<th>Do you have any difficulties hearing when there is background noise?</th>
<th>Y/N</th>
<th>Details/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do you have difficulties understanding in one-to-one conversations?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you have difficulties hearing the TV?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you have difficulties hearing on the telephone?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you have any dizziness or balance problems?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you find external sounds unpleasant or uncomfortable?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you dislike certain external sounds?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you wear ear protection / ear plugs?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tinnitus History Questionnaire

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

<table>
<thead>
<tr>
<th></th>
<th>Hearing Loss</th>
<th>Tinnitus</th>
<th>Sensitivity to Loud Sounds</th>
</tr>
</thead>
</table>

Effect of the Tinnitus

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

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?
NEW PATIENT CONTACT FORM

Date: ____________________________

Name of Person Providing Information: ________________________________________________________________

Relationship to Child: ________________________________________________________________

<table>
<thead>
<tr>
<th>Caregiver(s) Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Responsible Person Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ins. Company:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member ID#:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ins. Phone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:
**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  Parent #2
Name: ___________________________  Name: ___________________________
Age: ___________________  Age: ___________________
Occupation: ___________________________  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? Y or N
If yes, please explain:

____________________________________________________________________________

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC

B.4.2
**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:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
**Has your child been seen previously by a:**

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

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? ________________

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
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.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Child</th>
<th>Age</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
<table>
<thead>
<tr>
<th></th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wake Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After School Event/Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evening Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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? __________________________

*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
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:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Y or N</th>
<th>Frequency</th>
<th>Level of Child’s Enjoyment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conversations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits with Relatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Games</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trips</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out to Dinner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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?

__________________________________________________________

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
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.

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

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
Please check any past, present, or impending special problems in your family:

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

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: ___________________________

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
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?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Type</th>
<th>Severity Level (1 to 5)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Related</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retention (repeated Grades)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Academically</th>
<th>Socially</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daycare/Preschool/Headstart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

*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
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) :

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Y/N</th>
<th>Frequency</th>
<th>Intensity</th>
<th>Duration</th>
<th>List with Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fears</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irritation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explosive Outbursts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gets Upset Easily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cruel to Animals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sets Fires</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Y/N</th>
<th>Frequency</th>
<th>Intensity</th>
<th>Duration</th>
<th>List with Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breaks Things Belonging to Himself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breaks things Belonging to Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased Energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased Energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss in Interest in Activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased Interest in Danger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Taking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oversleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot go to Sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night Terrors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent Awakenings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased Appetite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased Appetite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overeating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced Vomiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of laxatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smokes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses/Abuse Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs Rituals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sees Things That Are Not There</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obsessive Concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hears Things That People Do Not</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeats Specific</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Y/N</th>
<th>Frequency</th>
<th>Intensity</th>
<th>Duration</th>
<th>List with Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeats Behaviors Over and Over Again</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal Thoughts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicidal Thoughts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns with Physical Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid Mood Changes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worthlessness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Self-Esteem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Aches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wets Bed/Clothes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swears/Curses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fidgety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impulsive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperactive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runs Away</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can’t Wait Turn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doesn’t Share</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doesn’t Listen/Doesn’t Follows Instructions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forgets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harms Self</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harms Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language Difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Y/N</th>
<th>Frequency</th>
<th>Intensity</th>
<th>Duration</th>
<th>List with Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rocks Back and Forth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tantrums</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangs Head</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bites Nails</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulls Hair/Eye Lashes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sucks Thumb/Fingers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overly Neat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perfectionism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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: __________________

____________________________________________________________________________

*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
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 ______________________________________________________________

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
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? ________________________________

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
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 quiet? ______________________ 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 question mark. If you don’t remember the age at which the behavior occurred, please write a question mark.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Age</th>
<th>Behavior</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Showed response to mother</td>
<td>Put several words together</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rolled over</td>
<td>Dressed self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sat alone</td>
<td>Became toilet trained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crawled</td>
<td>Stayed dry at night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walked alone</td>
<td>Fed self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Babbled</td>
<td>Rode tricycle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spoke first word</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Early Childhood**

Child walked: Child spoke words: Child spoke sentence:

<table>
<thead>
<tr>
<th>&lt; 12 months</th>
<th>&lt; 12 months</th>
<th>&lt; 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>12–24 months</td>
<td>12-24 months</td>
<td>12-24 months</td>
</tr>
<tr>
<td>24-36 months</td>
<td>24-36 months</td>
<td>24-36 months</td>
</tr>
<tr>
<td>&gt; months</td>
<td>&gt; months</td>
<td>&gt; months</td>
</tr>
<tr>
<td>has never walked</td>
<td>has never spoken words</td>
<td>has never spoken sentences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Circle all</th>
<th>that apply:</th>
<th></th>
<th></th>
<th>Slow to warm up</th>
<th>Fussy</th>
<th>Unpredictable sleep patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>Easy</td>
<td>Friendly</td>
<td>Easy going</td>
<td>Regular sleep patterns</td>
<td>Difficult</td>
<td>Slow to warm up</td>
<td>Fussy</td>
</tr>
<tr>
<td>Toddlerhood</td>
<td>Active</td>
<td>Adventuresome</td>
<td>Can focus attention</td>
<td>Moody</td>
<td>Outgoing</td>
<td>Passive</td>
<td>Clingy</td>
</tr>
<tr>
<td>Preschool</td>
<td>Separated Easily</td>
<td>Got Along with Peers</td>
<td>Got Along with Adults</td>
<td>Difficult Separating</td>
<td>Problems with Peers</td>
<td>Behavior Problems</td>
<td></td>
</tr>
<tr>
<td>Latency</td>
<td>Got Along with Peers</td>
<td>Problems with Peers</td>
<td>School Behavior Problems</td>
<td>Got Along with Adults</td>
<td>Poor Relationship with Teacher/Adults</td>
<td>Performs Well at School</td>
<td></td>
</tr>
<tr>
<td>Adolescence</td>
<td>Got Along with Peers</td>
<td>School Behavior Problems</td>
<td>Gets Along with Teacher/Adults</td>
<td>Problems with Peers</td>
<td>Performs Well at School</td>
<td>Poor Relationship with Teacher/Adults</td>
<td>Has Several Friends</td>
</tr>
</tbody>
</table>

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
**Puberty**

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

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

**MEDICAL HISTORY**

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

Other:

________________________________________________________________________________

Present Medications: ________________________________________________________________

<table>
<thead>
<tr>
<th>Type:</th>
<th>Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose:</td>
<td>Dose:</td>
</tr>
<tr>
<td>Frequency:</td>
<td>Frequency:</td>
</tr>
</tbody>
</table>

Pediatrician Name: ___________________________  Contact #: ___________________________

**LEGAL HISTORY**

Physical Abuse (Y/N) Describe: _______________________________________________________

Date of Report: _________________________________________________________________

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC
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: ____________________________ 

*Developed from the Oxford Play Therapy Training Institute & Counseling Center/ * Adapted from BASC 
CAREGIVER’S EXPECTATIONS OF SERVICES:

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

_________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
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
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  

B.5.1
**Patient Goals:**

**Pain Management:**

**Sensorimotor:**

<table>
<thead>
<tr>
<th>Touch/Perception/Visual</th>
<th>Intact</th>
<th>Impaired</th>
<th>Absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Light Touch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharp/Dull</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proprioception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinesthesia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stereognosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spatial Neglect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual Fields</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>AROM</th>
<th>PROM</th>
<th>AROM</th>
<th>PROM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Shoulder Extension</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shoulder Flexion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shoulder Abduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shoulder Adduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shoulder External Rotation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shoulder Internal Rotation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elbow Extension</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elbow Flexion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Forearm Supination</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Forearm Pronation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wrist Extension</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wrist Flexion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wrist Ulnar Deviation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wrist Radial Deviation</td>
<td></td>
</tr>
</tbody>
</table>

Limitations present:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Grip/Pinch

<table>
<thead>
<tr>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>#2</td>
</tr>
<tr>
<td>Grip</td>
<td></td>
</tr>
<tr>
<td>Lateral Pinch</td>
<td></td>
</tr>
<tr>
<td>Tip Pinch</td>
<td></td>
</tr>
<tr>
<td>3 point Pinch</td>
<td></td>
</tr>
</tbody>
</table>

Neuromuscular:

Activities of Daily Living:

Cognition:

Psychosocial:

Assessment:

Goals:
By discharge, patient will:

Intervention Plan:

Therapist Name ________________________ LA OT License # ________________________ Date ________________________
### Department of Occupational Therapy Clinic

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

---

#### ICD-10-CM Code

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PRIMARY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SECONDARY</td>
</tr>
</tbody>
</table>

#### CPT

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

---

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:**
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 ________

B.5.4
PATIENT ADMISSION FORM

Account number: ___________________________ Appointment Date: ___________________________

Chart Number: ___________________________ Physical Therapist: ___________________________

Referring Physician: ________________________ Phone #: ______ - ______ - ______

Referring Physician NPI#: ___________________ Fax #: ______ - ______ - ______

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

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

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

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

☐ Cancer  ☐ Diabetes  ☐ Tuberculosis
☐ Heart problems  ☐ Stroke  ☐ Thyroid problems
☐ High blood pressure  ☐ depression  ☐ 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? ________________________________

Eody 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
- Dull/aching pain
- Numbness
- Tingling

My symptoms currently: □ Come and go □ Are constant □ Are constant, but change with activity

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 problem 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: _______
<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes/No/Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Does looking up increase your problem?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>E2</td>
<td>Because of your problem, do you feel frustrated?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>F3</td>
<td>Because of your problem, do you restrict your travel for business or recreation?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>P4</td>
<td>Does walking down the aisle of a supermarket increase your problems?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>F5</td>
<td>Because of your problem, do you have difficulty getting into or out of bed?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>F6</td>
<td>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?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>F7</td>
<td>Because of your problem, do you have difficulty reading?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>P8</td>
<td>Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>E9</td>
<td>Because of your problem, are you afraid to leave your home without having someone accompany you?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>E10</td>
<td>Because of your problem have you been embarrassed in front of others?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>P11</td>
<td>Do quick movements of your head increase your problem?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>F12</td>
<td>Because of your problem, do you avoid heights?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>P13</td>
<td>Does turning over in bed increase your problem?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>F14</td>
<td>Because of your problem, is it difficult for you to do strenuous homework or yard work?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>E15</td>
<td>Because of your problem, are you afraid people may think you are intoxicated?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>F16</td>
<td>Because of your problem, is it difficult for you to go for a walk by yourself?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>P17</td>
<td>Does walking down a sidewalk increase your problem?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>E18</td>
<td>Because of your problem, is it difficult for you to concentrate</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>F19</td>
<td>Because of your problem, is it difficult for you to walk around your house in the dark?</td>
<td>Yes/No/Sometimes</td>
</tr>
<tr>
<td>E20. Because of your problem, are you afraid to stay home alone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Sometimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E21. Because of your problem, do you feel handicapped?</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Yes</td>
</tr>
<tr>
<td>o Sometimes</td>
</tr>
<tr>
<td>o No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E22. Has the problem placed stress on your relationships with members of your family or friends?</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Yes</td>
</tr>
<tr>
<td>o Sometimes</td>
</tr>
<tr>
<td>o No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E23. Because of your problem, are you depressed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Yes</td>
</tr>
<tr>
<td>o Sometimes</td>
</tr>
<tr>
<td>o No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F24. Does your problem interfere with your job or household responsibilities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Yes</td>
</tr>
<tr>
<td>o Sometimes</td>
</tr>
<tr>
<td>o No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P25. Does bending over increase your problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Yes</td>
</tr>
<tr>
<td>o Sometimes</td>
</tr>
<tr>
<td>o No</td>
</tr>
</tbody>
</table>

### DHI Scoring Instructions

The patient is asked to answer each question as it pertains 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.

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants: 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.

How confident are you that you will not 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? _____%


Total ABC Score: __________

Scoring: _________ / 16 = _________% of self confidence
P01: Positive and Negative Affect Scale (PANAS)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word, indicating to what extent you feel this way right now, that is, at the present moment. Use the following scale to record your answers:

1 2 3 4 5
very slightly a little moderately quite a bit extremely

interested distressed alert
interested moderately interested
excited a bit

upset inspired

strong

guilty

strong

guilty

scared

hostile

enthusiastic

proud

irritable
detennined

nervous

attentive

active

afraid
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:
<table>
<thead>
<tr>
<th>Problem</th>
<th>Date</th>
<th>After Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Indicate past (p) and current (c) illnesses

- Allergies
- Asthma
- Chicken pox
- Chronic Illness
- Concussions
- Convulsions, Spasms, seizures
- Diabetes
- Dizziness
- Earaches
- Excessive colds
- Headaches
- Hearing difficulties
- High fever
- Laryngitis
- Measles
- Meningitis
- Nausea
- Noises in the ear
- Oral cancer
- Pneumonia
- Sinus problems
- Sore throat
- Speech difficulties
- Swallowing problems
- Thyroid problems
- Tonsillitis
- 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 finding the right word
- Difficulty swallowing
- Difficulty to get others to understand them
- Difficulty expressing what they want to say
- 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? Yes _____________ 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 __________________________________________
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)

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Grade in school</th>
<th>Any Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


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)

<table>
<thead>
<tr>
<th>Box</th>
<th>Box</th>
<th>Box</th>
<th>Box</th>
<th>Box</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>bleeding</td>
<td>swelling</td>
<td>high blood pressure</td>
<td>low blood pressure</td>
<td>convulsions</td>
<td>toxemia</td>
</tr>
<tr>
<td>x-rays</td>
<td>smoking</td>
<td>excessive weight gain</td>
<td>excessive weight loss</td>
<td>diabetes</td>
<td>drink alcohol</td>
</tr>
<tr>
<td>asthma</td>
<td>surgeries</td>
<td>heart condition</td>
<td>thyroid condition</td>
<td>rubella</td>
<td>accident</td>
</tr>
<tr>
<td>kidney disease</td>
<td>substance abuse</td>
<td>Other</td>
<td>Add other conditions:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Box</th>
<th>Age</th>
<th>Box</th>
<th>Age</th>
<th>Box</th>
<th>Age</th>
<th>Box</th>
<th>Age</th>
<th>Box</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>Age</td>
<td>Mumps</td>
<td>Age</td>
<td>Chicken pox</td>
<td>Age</td>
<td>Frequent Colds</td>
<td>Age</td>
<td>Allergies</td>
<td>Age</td>
</tr>
<tr>
<td>Mumps</td>
<td>Age</td>
<td>Chicken pox</td>
<td>Age</td>
<td>Frequent Colds</td>
<td>Age</td>
<td>Allergies</td>
<td>Age</td>
<td>Speech difficulties</td>
<td>Age</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>Age</td>
<td>Frequent Colds</td>
<td>Age</td>
<td>Allergies</td>
<td>Age</td>
<td>Speech difficulties</td>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>Age</td>
<td>Pneumonia</td>
<td>Age</td>
<td>Convulsions, spasms or seizures</td>
<td>Age</td>
<td>How many convulsions, spasms or seizures?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Age</td>
<td>Convulsions, spasms or seizures</td>
<td>Age</td>
<td>How many convulsions, spasms or seizures?</td>
<td>Age</td>
<td>When was the last convulsions, spasms or seizures?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Describe these medical problems

________________________________________________________

What medication is the child taking? ________________________
What surgery has the child had? ____________________________
Has child had an EEG (Brain wave test)? __________ When? _
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:)

<table>
<thead>
<tr>
<th>Fed self</th>
<th>Toilet trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sat alone</td>
<td>spoon</td>
</tr>
<tr>
<td>Walked alone</td>
<td>fork</td>
</tr>
</tbody>
</table>

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 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? ____Yes 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___________)  Muscular Dystrophy
Aphasia  Laryngectomy
Dysarthria  Cognitive Disorders
Apraxia  Autism
Amyotrophic lateral sclerosis (ALS)  Multiple sclerosis
Seizure disorder  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):

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Purpose</th>
<th>Prescribing physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:
If not, does the individual require:
   _____ 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  __________ On floor

_________ In chair  __________ Side lying

_________ In bed  __________ Other ________________________________

_________ With walker

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  _______ 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: ________________________________

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):

<table>
<thead>
<tr>
<th>Tests</th>
<th>Date given</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Speech</th>
<th>Eye pointing</th>
<th>Vocalization</th>
<th>Spoken “yes-no”</th>
<th>Manual Signing</th>
<th>Gestural “yes-no”</th>
<th>Bodily Gestures</th>
<th>Communication Device</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 no, pointing)
- Signing Exact English
- American Sign Language
- Signed English
- Cued Speech
- Other (please specify) __________________________

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.

<table>
<thead>
<tr>
<th>System</th>
<th>Successful</th>
<th>Unsuccessful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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? __________________________

1 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:

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Therapist</th>
<th>Address</th>
<th>Phone</th>
<th>Dates Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Grade</th>
<th>Speech-Language-Hearing or Medical Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Age</th>
<th>Mild, Average, or Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent cases of the flu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scarlet Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tonsillitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whooping cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date of surgery</th>
<th>Physician</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Purpose</th>
<th>Prescribing physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 move 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

Page | 5
(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):

<table>
<thead>
<tr>
<th>Tests</th>
<th>Date given</th>
<th>Results</th>
</tr>
</thead>
</table>


**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.)

<table>
<thead>
<tr>
<th>Speech</th>
<th>Vocalization</th>
<th>Manual Signing</th>
<th>Bodily Gestures</th>
<th>Facial Expression</th>
<th>Eye pointing</th>
<th>Spoken “yes-no”</th>
<th>Gestural “yes-no”</th>
<th>Communication Device</th>
</tr>
</thead>
</table>

**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)
_____ Signing Exact English
_____ Duffy's Innovative Sign System
_____ Finger Spelling
_____ 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.

<table>
<thead>
<tr>
<th>System</th>
<th>Successful</th>
<th>Unsuccessful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How are vocabulary items represented on the child'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)

*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:

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Therapist</th>
<th>Address</th>
<th>Phone</th>
<th>Dates Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ____________________________ Phone: ____________________________

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 ___________________________
<table>
<thead>
<tr>
<th>Received From</th>
<th>Dollars($)</th>
<th>Patient</th>
<th>Account#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check No.</td>
<td>Date of Check</td>
<td>Cash$</td>
<td>Dept.</td>
</tr>
<tr>
<td>Received By</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LSUHealthNewOrleans**

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

---

<table>
<thead>
<tr>
<th>Received From</th>
<th>Dollars($)</th>
<th>Patient</th>
<th>Account#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check No.</td>
<td>Date of Check</td>
<td>Cash$</td>
<td>Dept.</td>
</tr>
<tr>
<td>Received By</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LSUHealthNewOrleans**

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

---

<table>
<thead>
<tr>
<th>Received From</th>
<th>Dollars($)</th>
<th>Patient</th>
<th>Account#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check No.</td>
<td>Date of Check</td>
<td>Cash$</td>
<td>Dept.</td>
</tr>
<tr>
<td>Received By</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LSUHealthNewOrleans**

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

---

<table>
<thead>
<tr>
<th>Received From</th>
<th>Dollars($)</th>
<th>Patient</th>
<th>Account#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check No.</td>
<td>Date of Check</td>
<td>Cash$</td>
<td>Dept.</td>
</tr>
<tr>
<td>Received By</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LSUHealthNewOrleans**

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

---

<table>
<thead>
<tr>
<th>Received From</th>
<th>Dollars($)</th>
<th>Patient</th>
<th>Account#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check No.</td>
<td>Date of Check</td>
<td>Cash$</td>
<td>Dept.</td>
</tr>
<tr>
<td>Received By</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

C.1
ALLIED HEALTH DAILY DEPOSITS

ROUTING TICKET #.................................
FOR THE DAY OF ..................................

SAID TO CONTAIN       RECEIVED & VERIFIED
CASH.................................       CASH ........................................
CHECKS ..............................       CHECKS ..............................
VISA .................................       VISA .................................

DISCOVER ..............................       DISCOVER ..............................
TOTAL .................................       TOTAL .................................

RECEIPT NUMBERS       RECEIPT NUMBERS

__________  __________

__________  __________

__________  __________

__________  __________

__________  __________

PREPARED & SUBMITTED BY: RECEIVED & VERIFIED BY:

__________________________  ________________________
CASHIER                        AH BILLING OFFICE

C.2
### Patient Information

- **Name:** New Orleans, LA 70112

### Provider Information

- **Name:**
- **Account:**
- **Insurance Co.:**
- **Authorization #:**
- **Diag#:**
- **Location:**

### Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Intake/Interview Session</td>
<td>$180.00</td>
</tr>
<tr>
<td>90839</td>
<td>Crisis Psychotherapy</td>
<td>$150.00</td>
</tr>
<tr>
<td>90840</td>
<td>Add add'l 30 min</td>
<td>$100</td>
</tr>
<tr>
<td>90832</td>
<td>Individual Psychotherapy 30 min</td>
<td>$100</td>
</tr>
<tr>
<td>90834</td>
<td>Individual Psychotherapy 45</td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Individual Psychotherapy 60 minutes</td>
<td>$175</td>
</tr>
<tr>
<td>90808</td>
<td>Individual Psychotherapy 75–80 min</td>
<td>$200</td>
</tr>
<tr>
<td>90834</td>
<td>Interactive Psychotherapy 45 min</td>
<td>$135</td>
</tr>
<tr>
<td>90875</td>
<td>Interactive Complexity</td>
<td>$10</td>
</tr>
<tr>
<td>90849</td>
<td>Multi–family group treatment</td>
<td>$150</td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy 45–50 min</td>
<td>$100</td>
</tr>
<tr>
<td>90846</td>
<td>Family Psychotherapy 45–50 min</td>
<td>$125</td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy 45–50 min with patient</td>
<td>$135</td>
</tr>
<tr>
<td>90887</td>
<td>Training</td>
<td></td>
</tr>
<tr>
<td>90889</td>
<td>Report Writing x</td>
<td>$125 HR</td>
</tr>
<tr>
<td>96101</td>
<td>Testing/Evaluation X</td>
<td>$175 HR</td>
</tr>
<tr>
<td>99070</td>
<td>Court Testimony X</td>
<td>$500 HR</td>
</tr>
<tr>
<td>99070</td>
<td>Consultation X</td>
<td>$125 HR</td>
</tr>
<tr>
<td>99199</td>
<td>Missed Session X</td>
<td>$100/HR</td>
</tr>
<tr>
<td>98966</td>
<td>Telephone Assessment &lt; 10 min</td>
<td></td>
</tr>
<tr>
<td>98967</td>
<td>Telephone Assessment 11–20 min</td>
<td></td>
</tr>
<tr>
<td>98968</td>
<td>Telephone Assessment 21–30 min</td>
<td></td>
</tr>
<tr>
<td>99070</td>
<td>Emails</td>
<td></td>
</tr>
<tr>
<td>99070</td>
<td>School Observation x</td>
<td>$150 HR</td>
</tr>
</tbody>
</table>

### Billing Information

- **Copay**: 
- **COINSURANCE**: 
- **Check #**: 
- **Check Date**: 
- **Credit Card**: 
- **Cash**: 
- **Misc**: 
- **Comment**: 

### Procedure Code Approval

- **Visit’s used**: 
- **Visit’s remaining**: 

### Signature

**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**

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:**