OLLU OUR LADY OF THE LAKE UNIVERSITY
Woolfolk School of Communication Sciences and Disorders

HARRY JERISG CENTER, 411 S.W.24TH Street, San Antonio, Texas, 78207, Phone: 210.431.3938

Thank you for contacting the Harry Jersig Center regarding speech/language services and we hope to have the opportunity to address the communication needs for you or your family member. Please understand that this is a teaching clinic (Communication Sciences and Disorders) which requires that clients be admitted based upon the clinical experiences needed by our graduate students. Completion of the intake form will allow us to determine if/when your child will receive services in our clinic.

Completion of this form is the first step in the admittance process. You will be notified of your application status and further requirements via e-mail and/or phone.

Fees for Services.

Currently, there is no fee for services, however donations are welcome to help the clinic maintain materials, and clinic upkeep for client services.

Student involvement.

As part of the Woolfolk School of Communication Sciences and Disorders at Our Lady of the Lake University, the Harry Jersig Center is a training facility for graduate students studying to be speech pathologist. Therefore, most of our services are provided by university students under the supervision of state licensed and nationally certified speech-language pathologists. We operate on a university calendar, and services are provided on a semester basis, i.e., Fall (Sept-Dec), Spring (Jan-May), Summer (JunJul).

Admission Process.

After completing this intake for evaluations or treatment, please follow the procedures listed below:

1. Bring, mail, e-mail or fax the completed packet to the Harry Jersig Center at Our Lady of the Lake University.
    - E-mail: jersigcenter@ollusa.edu
    - Fax: 210.434.9360
2. If you are interested in services, you will be contacted to set up an appointment time.
3. If you have more questions about our services, please contact Rosa Lydia Martinez (Clinic Director at ext.6590).

Please note that admission is dependent on availability of appointment times.

We hope this information will be of use to you, and that you feel free to call us if you have any further questions.

Sincerely,

Rosa Lydia Martinez, M.S., CCC-SLP

Rosa Lydia Martinez

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Adult Case History Form

Please fill out this form as completely as possible, especially the items marked with an asterisk. If you need more space,attach another page, or write on the back. Call 431-3938 if you have additional questions regarding these forms.

Client's Name:_____

Address:_____

E-mail: _____

Date of Birth:_____ **Place of Birth:**_____ **Age:**_____

Grade:_____ **Gender:**_____ **Daytime Phone (Home/Cell):**_____

Reason for Referral:_____

Name of Referral Source:_____

Spouse or Responsible party:_____

Which of the following services are you requesting?

DIAGNOSTIC SERVICES	Please check services requested	TREATMENT SERVICES	Please check services requested
SPEECH-LANGUAGE EVALUATION		Speech-Language Therapy	
COGNITIVE EVALUATION		Cognitive Therapy	
HEARING EVALUATION		Individual therapy	
HEARING AID EVALUATION		Group therapy	
SWALLOWING EVALUATION		Aural rehabilitation	
VOICE EVALUATION		Voice Therapy	
Accent Modification Scrng/Evaluation		Accent Modification Scrng/Evaluation	
Stuttering/Fluency Evaluation		Stuttering/Fluency Evaluation	
Other:			

What are your expectations from this appointment?

_____speech-language developmental level

_____recommendations for things I can do at home

_____enrollment in therapy or classes

_____other (explain) _____

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Complaint

Why do you wish to be evaluated at our clinic? Please describe your communication problem.

What would you hope to gain through the use of our services?

When and where did you have previous communication therapy? Please describe.

Are there any particular times of the day or situations in which your problem in worse? If so, please describe.

Are there any particular times of the day or situations in which your problem is better? If so, please describe.

Have you ever experienced any of the following? Please check.

	Approximate Date(s) Year	
☐		Difficulty saying the sounds of English
☐		Difficulty recalling the words you wish to say
☐		Voice Problems
☐		Hearing Problems

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Medical

Have you had any recent or prolonged illness? If so, please describe:

Are you presently taking any medication? If so, please list and indicate reason for taking them.

Describe any surgery you have had. Indicate year of surgery.

Describe any significant accidents you have had and indicate dates.

Have you ever had any of the following? Please check.

Have you ever had any of the following? Please check.

_____	_____	Influenza	_____	_____	Scarlet fever
_____	_____	Heart disease	_____	_____	Meningitis
_____	_____	Weakness of arms or legs	_____	_____	Allergies
_____	_____	Uncontrolled trembling	_____	_____	Sinus Problems

_____ _____ Difficulty in swallowing _____ _____ Frequent colds

_____ _____ Shortness of breath _____ _____ Thyroid problems

_____ _____ Measles _____ _____ Other (explain)

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AUTHORIZATION OF RELEASE OF INFORMATION OBTAINED DURING TREATMENT OF ASSESSMENT

1. I hereby authorize the agents of the Harry Jersig Communication Disorders Program, exercising due discretion, to use the following items (circled) of either myself or my child, for whom I am legally responsible.

   A. Make audio recordings of sessions. Yes No

   Make video recordings of sessions. Yes No

   Take photographs during sessions. Yes No

2. I authorize that you use these not only as a record of the session, but also for the following:

   A. For clinical purposes (e.g., verification of data collected) Yes No

   For educational observations (e.g., classroom demonstration) Yes No

   For professional research. Yes No

   For public meetings (e.g., high school career day programs, science fairs, club meetings or booth displays, HJC website, etc.) Yes No

   For purposes of public relations or news media (e.g., newspapers, Website, newsletter, television, information brochures) Yes No

   Authorize live observations of sessions by students in the Communication Disorders Program at OLLU. Yes No

   To ALL of the above. Yes No

Signature of client, parent and/or guardian: _____

Relationship to client: _____

Release date authorized from:

_____Start date of therapy and after the end date of therapy for reasons circled above

_____Start date of therapy to end date of therapy for reasons circled above

Client's name: _____

Date of Birth: _____

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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Harry Jersig Center at the Our Lady of the Lake University to release/request the following information from the health record(s) of:

Patient Name: _____ DOB: _____

Address: _____

City, State, & Zip Code: _____

Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 {45 CFR & 164.508}.

1. I authorize Harry Jersig Center, Our Lady of the Lake, to request copies of the following types of records from:

   _____

   _____

   ☐ Complete health records

   ☐ Speech and Language evaluations

   ☐ Audiological and/or Ontological records

   ☐ Observation of child in classroom

   ☐ Educational records, including achievement test scores, individual Academic/Psychometric Evaluations, Psychological Evaluation, ARD/IEP

2. I authorize the Harry Jerisg Center at Our Lady of the Lake University to release the following type(s) of records to: _____

   ☐ Speech and Language records

   ☐ Audiological records

I understand this consent can be revoked, in writing, at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Specification of the date, event, or condition upon which is consent expires _____.

The facility, its employees and officers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____

Signature (Self/Parent/Guardian)

Please Print Name: _____