



Harry Jersig Center 411 S.W. 24th Street San Antonio, TX 78207 (210) 431-3938

Thank you for contacting the Harry Jersig Center regarding speech/language services. Enclosed are the following forms:

Case History.

Since information about your medical, social, and education history helps us select appropriate tests to administer, we ask that you complete the enclosed case history form and return it to us in the enclosed postage paid reply envelope, before you are given an appointment.

Authorization for Release and/or Use of Clinical Material.

Please sign and return the enclosed release form if you wish us to request information from doctors or if you wish us to send a copy of the final diagnostic report to anyone.

Authorization for Audio-Video Taping

Please refer to, at least, the highlighted items and select "yes" so that we can audio and video tape for clinical purposes only (i.e., analyzing the session for data and training purposes). Refer to the rest of the document and complete.

Fees for Services.

Please contact the bookkeeper at the Harry Jersig Center for more information.

Student involvement.

As part of the Communication disorders Program at Our Lady of the Lake University, the Harry Jersig Center is a training facility for university 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 professional staff. We operate on a university calendar, and services are provided on a semester basis, i.e. Fall (Sept-Dec), Spring (Jan-May), Summer (Jun-Jul).

Admission Process.

After completing this packet 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.
2. The bookkeeper will contact you to see if you are interested in obtaining information regarding our fee schedule.
3. If you are interested in services, you will be contacted to set up an appointment time.
4. If you have more questions about our services, please contact Rosa Lydia Martinez (Clinic Director at ext. 2401).

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 Martínez, M.S., CCC-SLP

A Program Dedicated to the Evaluation, Diagnosis and Treatment of Language, Speech, Voice, Swallowing, Feeding, and Hearing Disorders of Children and Adults.
Graduate Education and Clinical Service Programs in Audiology and Speech-Language Pathology accredited by the Council of Academic Accreditation of the American Speech-Language-Hearing Association.

An Equal Opportunity/Affirmative Action University



OUR LADY OF THE LAKE UNIVERSITY

Harry Jersig Center
Communication Disorders Department

ADULT CASE HISTORY

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.

Date: _____

*Reason for referral: _____ Referring person: _____

*Name of Client: _____ Social Security #: _____ Gender: F M

* Birthdate: _____ *Age: _____ Home Ph: _____ Cell: _____ Work: _____

Best time to call: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Spouse or responsible party: _____ Age: _____

Which of the following services are you requesting?

DIAGNOSTIC SERVICES	Please check services that apply	TREATMENT SERVICES	Please check services that apply
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		Other:	

*How will you pay for services? _____ Insurance Co.? _____

Please include copy of insurance card with this case history form.

Please provide doctor's written referral if needed.

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) _____

How did you become aware of the Harry Jersig Center?

- teacher Our Kids Magazine television
- pediatrician friend other (specify) _____
- ENT yellow pages internet
- neurologist Today's Catholic Express News
- speech-language pathologist

Medical History

What is your medical diagnosis? _____

Date of onset? _____

Current Medications	Dosage	Physician

Please state what you think is the problem – describe: _____

How was your speech/language/cognition/swallowing/voice before this happened? _____

Please check those symptoms that describe your condition:

- Hearing Loss
- Difficulty understanding what people say
- Difficulty thinking of and saying words
- Difficulty reading or writing
- Confused or difficulty thinking things through
- Memory difficulty (long term or short term)
- Slow or slurred speech
- Hoarse voice
- Difficulty swallowing/choking or coughing on foods or liquids
- Need of assistance in walking

Check those conditions with which you have been diagnosed:

_____ High Blood Pressure

_____ Heart Attack

_____ Stroke

_____ Neurological Disorders (i.e., Parkinsons)

_____ Brain Injury/Anoxia

_____ Seizure disorder

_____ Respiratory Problems

_____ Pneumonia

_____ Dysphagia

_____ Vocal Nodules/polyps

_____ Vocal cord paralysis

_____ Visual difficulties

_____ Paralysis

Current general health? _____

Any other serious or recurrent illnesses? _____ When? _____

Any operations? _____ When? _____

Any accidents? _____ When? _____

Any medications? (Past) _____ (Current) _____

*Hearing difficulties? _____ If so, Aided? _____

Vision problems? _____ If so, treatment? _____

Dental Problems: _____ Treatment: _____

Other: _____ Left or right handed? _____

Personal Medical information

Personal Primary Physician: _____ Date of last visit: _____

Address or Location: _____

Ongoing Medical Care (Describe): _____

Physician's Name: _____ City: _____

Chronic Health Problems (Asthma, Congenital Defects, etc.): _____

Handicaps (Describe, if any): _____

Speech and Language

Do you know of any concerns regarding early speech and language development? _____ Describe: _____

Other language(s) spoken in the home: _____

Have you ever had difficulty understanding or expressing yourself? _____ Describe: _____

*What are your communication needs in social settings? _____

*What difficulty do you have meeting your communication needs? _____

Job/Educational History

*How have communication difficulties affected the types of jobs you have held? _____

*Describe your current job setting and your communication needs: _____

*How do communication problems affect your current job: _____

*Does your communication difficulty affect your future job plans? _____ Explain: _____

General Information

Hobbies: _____

Social and/or civic groups to which you belong: _____

Other information you would like us to know: _____

***PLEASE MAIL THE COMPLETED FORMS TO:**

OUR LADY OF THE LAKE UNIVERSITY
HARRY JERSIG CENTER
COMMUNICATION DISORDERS DEPT.
411 S W 24TH STREET
SAN ANTONIO TX 78207

PLEASE SEND RELEVANT REPORTS AND INFORMATION FROM OTHER AGENCIES IN A SEPARATE ENVELOPE.



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AUTHORIZATION OF RELEASE OF INFORMATION OBTAINED DURING TREATMENT OF ASSESSMENT

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

- A. Yes _____ No _____ make audio recordings of sessions
- Yes _____ No _____ make video recordings of sessions
- Yes _____ No _____ take photographs during sessions

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

- B. Yes _____ No _____ 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, newsletters, television, information brochures)

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

3. Yes _____ No _____ to ALL of the above

Signature of client, parent and/or guardian: _____

Relationship to client: _____

Dates release authorized from:

_____ Start date of therapy and after the end date of therapy for reasons checked off above

_____ Start date of therapy to end date of therapy for reasons checked off 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 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 or records from:

- Complete health records
- Speech and Language evaluations
- Audiological and/or Otological 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 Jersig 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: _____