CAL STATE
EAST BAY

College of Letters, Arts, and Social Science
Norma S. and Ray R. Rees Speech Language and Hearing Clinic
25800 Carlos Bee Boulevard, Hayward, California 94542-3065
Phone: 510.885.3241 ● Fax: 510.885.2186 ● www.csueastbay.edu/commsci ● www.csueastbay.edu

WHO The clients represent all age groups from preschool children to senior citizens. Each client demonstrates a speech, hearing or language problem. These problems include, but are not limited to, articulation problems, language delays or disorders, voice problems, hearing loss, auditory perceptual impairments, dysfluency, aphasia, and dysarthria. The clinicians are graduate students preparing for careers in speech-language pathology or audiology who have completed considerable course work in communication processes and disorders. Students work under the direct supervision of speech pathologists and audiologists who hold the Certificate of Clinical Competence from the American Speech-Language- Hearing Association and who are licensed by the State of California.

The Department of Communicative Sciences and Disorders is committed to the principle of equal opportunity. The University, College and Department do not discriminate in the delivery of professional services or the conduct of research scholarly activity on the basis of race, ethnicity, religion, national origin, gender, gender-identity, sexual orientation, age, marital status, physical characteristics, or disability.

WHAT The clinic offers speech, hearing and language screening, evaluations, and treatment, including the development of home programs. An individualized therapy program is developed and implemented for each client. A full range of up-to-date equipment and materials is available. Students and family members may observe therapy through modern observation facilities. Please note that our clinic is unable to offer services for auditory processing disorders (as determined by an audiologist).

WHEN The therapy schedule is linked to the academic quarter at the university. For Fall, Winter and Spring 2017-2018, hourly sessions are held twice a week for nine weeks. The clinic itself is open Monday through Thursday, with individual 55-minute appointments starting on the hour between 9:00 am and 5:00 pm. Therapy is scheduled at times convenient to both clinicians and clients. Since students earn academic credit for providing therapy, a minimum of 15 hours of therapy is required each quarter for each client. Diagnostic evaluations are typically scheduled during academic quarters, though they may be scheduled during academic recesses if supervisors and students are available. The yearly clinic calendar is posted HERE.

WHERE The clinic is located in the Music Building, Room 1099, on the Cal State East Bay *Hayward* Campus.

WHY Speech-Language pathology and audiology services help prevent communication problems, help clients to communicate at their maximum potential, and help families to understand these problems and communicate more easily with each client.

HOW An application must be completed by the potential client or caregiver with legal authority to do so. Referrals are not required to apply for services. An application is considered complete when pertinent medical, social, and educational records have been received. The client is then scheduled for a diagnostic evaluation based on the training needs of our students. Results are discussed with the client and family and a report is sent upon request. If therapy is indicated, the client is advised regarding how to obtain appropriate services, either in our clinic or at another facility. The application can be emailed to clinic@csueastbay.edu, faxed to 510/885-2186, or mailed to CSUEB Dept. of CSD, Attn: Rees Clinic, 25800 Carlos Bee Blvd. MB1099, Hayward, CA 94542.

COST The clinic provides speech therapy and evaluation services to the community at no cost. Materials fees are assessed for some activities.

Donations are welcome. Checks are accepted at the reception desk, and can be made out to "CSUEB". You can also make donations on-line, at www.csueastbay.edu/clinicdonation

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For further information or to initiate a referral, contact the clinic at (510) 885-3241 or clinic@csueastbay.edu

CALIFORNIA STATE UNIVERSITY, EAST BAY
Department of Communicative Sciences and Disorders
Norma S. and Ray R. Rees Speech, Language and Hearing Clinic 510/885-3241

APPLICATION FOR CLINICAL SERVICES

DATE OF REQUEST:_____/______/______

Client First Name:		**Client** Last Name:
Date of birth: ______/______/____________	Age:	Gender:

Person to contact regarding this application

☐ **If you are an adult client completing the application for yourself, complete this section.**		☐ **If client is a minor, or adult unable to complete the application themselves, complete this section.**	
Address:		**Name:**	
Apt.		**Relationship:**	
City:		Do you have legal authority to sign documents and communicate on behalf of the prospective client? ☐ Yes ☐ No ☐ I don't know	
State:	Zip:		
Please check the main/preferred phone number(s) below:		*Please check the main/preferred phone number(s) below:*	
☐ Home:		☐ Home:	
☐ Cell:		☐ Cell:	
☐ Work:		☐ Work:	
Email:		Email:	
		Address:	
		Apt.	
		City:	
		State:	Zip:

Language(s) spoken in the home:
For child client, name of school, city, and district:
Child client's grade and/or special day class placement:

Speech and Language Information - Why are you seeking services at this time? Please use the box below. In your own words, what are the concerns about the client's ability to speak, use or understand language, produce speech sounds, or interact with others? Please include any behavioral concerns.

Has the prospective client had any previous speech, language or hearing **evaluations or treatment?**
☐ Yes ☐ No

If **YES,** do you have a copy of the most recent IEP or medical report?
☐ Yes ☐ No

If you checked "Yes" above, please provide a copy of the IEP or medical report. If you checked "No" above, please complete the Authorization for Release of Information form included with this application (page 4), and we will request the report(s) on your behalf. **Your application will not be able to be processed without these documents.** Additionally, please provide the information below:

	Provider	Dates of Service	Outcome/Recommendations
☐ Evaluation ☐ Treatment			
☐ Evaluation ☐ Treatment			
☐ Evaluation ☐ Treatment			
☐ Evaluation ☐ Treatment			
☐ Evaluation ☐ Treatment			

Does the client have a history of chronic ear infections or any chronic illnesses related to hearing or the ear?
☐ No ☐ Yes – Please provide details below:

Is there any family history of communication difficulties?
☐ No ☐ Yes – Please provide details below:

Please add any information you feel is important. Examples include details on previous diagnoses such as autism or stroke, details on medical history, social skills/challenges, educational history, etc.

Medical Information

Primary Doctor:	Phone:
☐ Private Practice or ☐ Facility – Name:	
Address:	
City, State and Zip:	
Does a **specialist** care for the client? (e.g., neurologist, ENT specialist?) ☐ No ☐ Yes; see below	
Name:	Area of Specialty:
Address:	
City, State and Zip:	Phone:
Food allergies:	
Medications:	

For CHILD client

Early developmental milestones (*please check*)

Crawling	☐ normal	☐ delayed	☐ unsure
Walking	☐ normal	☐ delayed	☐ unsure
First words	☐ normal	☐ delayed	☐ unsure
Combining words	☐ normal	☐ delayed	☐ unsure

School history

Social skills	☐ normal	☐ delayed	☐ unsure
Academics	☐ normal	☐ delayed	☐ unsure

For ADULT client

Family/Physical Information (*please check)*

Living alone	☐ yes	☐ no
Walking	☐ Independent	☐ needs assistance
Personal Care*	☐ Independent	☐ needs assistance

**Appropriate use of toilet*

Last Grade completed:	Where currently/last employed:

How did you hear of our clinic?

Has the client been seen by our clinic before? ☐ No ☐ Yes – Please provide the date range below:

Ex: October 2012 to June 2014

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☐ By checking this box, I confirm I have read and understand the information regarding materials fees above. I also understand my application may not be processed if previous available evaluation/treatment reports are not provided as part of this application.

Thank you for your application!

We will be in contact with you within 3 weeks if we are able to schedule you for an evaluation.

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Authorization for Release of Information

I authorize Name: ________________________ Facility: ___________________________
(if applicable)

Street: ________________________ City: __________________ State: ____ Zip: ______

Telephone: ______________________________ Fax: _____________________________

to release to the Speech, Language and Hearing Clinic, Cal State East Bay SPEECH-LANGUAGE-AUDIOLOGY records and information pertaining to

____
Name of Client Date of Birth Medical Record Number

____
Address City State Zip Code Telephone

AUTHORIZATION - You must have legal authority to request information. If you are acting as a legal representative to another individual, you must describe the legal relationship to act for the individual.
DURATION - This authorization shall become effective immediately and remain in effect for one year from the date of signature, unless otherwise indicated below.
REVOCATION - You may revoke this authorization, in writing, at any time. The written revocation will be effective upon receipt, but will not be effective to the extent that the person requesting information or others have acted in reliance upon this authorization.
REDISCLOSURE - You may not lawfully further use or disclose the health information to another unless another authorization is obtained or unless such disclosure is specifically required or permitted by law.
COPIES - You have a right to receive a copy of this release authorization form.
FEES - A fee of $1.00 per page will be charged for each page in excess of ten.

USE OF INFORMATION: The information will be used for the following purposes:

Speech-language evaluation and/or therapy preparation.

___________________________________ _______________________ ___________
Printed Name of Person Signing Release Signature Date

______________________________ ______________________________________
Legal Relationship to Client Expiration Date for Authorization
If left blank, this will be one year from the date signed.