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 ● www.csueastbay.edu/slhs/clinic ● www.csueastbay.edu

WHO WE ARE

We are a teaching clinic for students who are preparing for careers in Speech-Language Pathology. All services are provided by students under the supervision of certified and licensed professionals.

WHAT WE DO

Our clinic provides speech and language evaluations and treatment, including the development of home programs. Treatment may be provided in individual, paired, or group sessions. We serve clients with communication problems associated with stroke, developmental delays, autism, hearing loss, stuttering, cognition impairment, articulation, the voice, and others.

WHO WE SERVE

We provide services for all age groups, ranging from preschool to senior citizens. Our clients come from all over the Bay Area, using both private and public transportation.

WHAT IT COSTS

During the academic year, the clinic runs on a donation basis. Nominal materials fees are charged for evaluations and treatment. Payments can be made by cash, check, or credit card, and are accepted when services are provided.
As a donation-based clinic, we welcome donations at www.csueastbay.edu/clinicdonation

WHEN WE MEET

Our clinic offers 11-week sessions during the Fall and Spring, with length of session chosen to best meet client treatment and student training needs. Clients are typically seen either Monday/Wednesday or Tuesday/Thursday for 50-minutes. Our first appointments start at 9:00 a.m. and last appointments at 4:00 p.m., though we occasionally are open until 7:00 p.m.

WHERE WE ARE

Our address is:
Cal State East Bay
Rees Speech, Language and Hearing Clinic
25800 Carlos Bee Blvd., MB1099
Hayward, California 94542

MB1099, our clinical suite, is located in the Music Building. The MB is on the north side of campus, most easily accessed from Carlos Bee Blvd. Parking fees apply, including for those displaying a handicap placard.

HOW IT WORKS

All can apply for services; no referral is required. An evaluation must first be done at our teaching clinic before therapy services can be considered.

- Submit a complete application for services.
- Turn it in to us by email, mail, or in person.
  - Email: clinic@csueastbay.edu
- Include supporting papers such as IEP's or medical records.
  - The application is not considered complete if supporting papers exist but are not provided.
- Wait for us to contact you.

It usually takes 3 weeks for us to schedule the evaluation, and if you are referred for therapy, a scheduling form will be provided for the next available session, during which a clinician and supervisor will be matched to the client.

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

CLEAR FORM

CALIFORNIA STATE UNIVERSITY, EAST BAY
Department of Speech, Language, and Hearing Sciences
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 over 18 and completing this application for yourself, complete this section.**	☐ **IF client is under 18, or an adult who can't 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:
Would the family like an interpreter for the assessment? ☐ Yes ☐ No ☐ not applicable
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

COST Our community clinic operates on a donation basis. Nominal materials fees are charged for evaluations and treatment. Payments are accepted at the reception desk at time of services, and can be made by cash, check, or credit card. As a donation-based clinic, we welcome donations at www.csueastbay.edu/clinicdonation

☐ 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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The Department of Speech, Language, and Hearing Sciences
25800 Carlos Bee Boulevard, MB 1099
Hayward CA 94542-3065 Telephone: (510) 885-3241
Email: clinic@csueastbay.edu

Authorization for Release of Protected Health Information (PHI)

I authorize Name:_____ Facility: _____

Street:_____ City:_____ State:_____ Zip: _____

Telephone:_____ Fax: _____

to release to the Rees 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 - Authorizing disclosure of protected private health information, which may include sensitive information about behavioral or mental health, is voluntary. 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 - We 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.
USE OF INFORMATION: The information will be used for the following purposes:

Speech/language/hearing evaluation and/or therapy at the Rees Clinic.

_____ _____ _____
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.