Audiology Clinic
University of Maryland
Child Case History

Insurance:
We do not participate with any insurer; therefore, payment is due at the time of service. We will provide a copy of the itemized invoice with services rendered and/or devices dispensed that can be used to submit for reimbursement independently.

I. IDENTIFICATION

Name: _____ Age: _____ Date of Birth: _____

Phone number: _____ Cell/ Work: _____

Address: _____ City/State/Zip: _____

Referred by: _____ Reason for referral: _____

Pediatrician name: _____ Phone number: _____

Address: _____

Parent/Legal Guardian Name(s): _____

Address: _____ Address: _____

_____ _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell phone: _____ Cell Phone: _____

Does child live with (circle one): mother father both parents

II. HEARING LOSS HISTORY

Do you have any concerns about your child's hearing? Yes ( ) No ( )

If yes, explain _____

_____

Did your child pass their newborn hearing screening? Yes ( ) No ( )

Has your child had any previous hearing tests? Yes ( ) No ( )

If yes, please indicate where hearing test(s) was administered, date of test(s), results, and recommendations _____

_____

_____

Is there a family history of hearing loss? Yes ( ) No ( )

If yes, please indicate relationship of family member to patient, age of hearing loss identification, and degree of hearing loss _____

_____

_____

III. BIRTH HISTORY

Length of pregnancy: _____ Birth Weight: _____

Was the delivery normal? Yes ( ) No ( ) Please indicate problems (if any) at birth: _____

_____

IV. DEVELOPMENTAL BEHAVIOR

Motor

Ages of: Sitting up: _____ Crawling: _____ Walking: _____

Speech/Language

Ages of: Babble: _____ First word: _____ Short Sentences: _____

Does your child use understandable speech? Yes ( ) No ( ) If no, please describe: _____

_____

V. MEDICAL HISTORY (check all that apply)

Ear Aches ( ) Ear Infections ( ) Draining Ears ( ) PE Tubes ( ) Asthma ( )

Measles ( ) Mumps ( ) Chicken Pox ( ) Tonsils and Adenoids Removed ( )

Allergies ( ) Meningitis ( ) Encephalitis ( ) Seizures ( )

Other ( ) _____

Please explain any checked items: _____

_____

Does your child have any special behavior problems? Yes ( ) No ( ) If yes, please describe ___

_____

_____

VI. EDUCATIONAL HISTORY

Present school and grade: _____

_____

Is schoolwork satisfactory? Yes ( ) No ( ) If no, please describe _____

_____

Has he/she ever had special help of any kind? Yes ( ) No ( ) If yes, please describe _____

_____

Has the teacher noticed any problems? Yes ( ) No ( ) If yes, please describe _____

_____

Additional comments or information: _____

_____

_____

_____

Informant: _____

Examiner: _____ Date: _____

UNIVERSITY OF MARYLAND
Hearing & Speech Clinic

7251 Preinkert Drive
0110 Lefrak Hall
College Park, Maryland 20742
301.405.4218 TEL 301.314.2023 FAX
www.hespclinic.umd.edu

Consent Form (Required Form)

The Department of Hearing and Speech Sciences at the University of Maryland has three purposes: to train speech-language pathologists and audiologists, to render services to clients, and to conduct research in hearing, speech, and language. In order to meet these purposes, any of the following diagnostic, therapeutic, teaching, and/or research procedures may be used by authorized personnel within the department: direct observation, audio taping, video taping, photography, and review of client records. Supervised students may be involved in both observation of sessions and conducting sessions. For research purposes, clients may be asked to participate in research projects conducted by authorized personnel. Client participation in any research project is strictly voluntary, and refusal to participate will in no way affect clinical services rendered to the client.

I consent to the participation of _____ in the
Name of Client
programs of the Department of Hearing and Speech Sciences at the University of Maryland and have been made aware of the direct involvement of students in the services rendered.

I grant this consent with the understanding that any use of privileged information, other than to meet the department's stated purposes, will not be undertaken without further written consent.

Signature: _____ Date: _____

Print Name:_____

Address:_____

_____

Relationship to Patient: _____

The University of Maryland complies with all applicable federal, state, and local laws, including, but not limited to, the Americans with Disabilities Act of 1990, the Civil rights Act of 1964, the Equal Pay Act, the Age Discrimination in Employment Act, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (to the Higher Education Act of 1965), the Rehabilitation Act of 1973, the Vietnam-Era Veterans Readjustment Assistance Act 1974, and all amendments to the foregoing.

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Authorization for Release of Records from the University of Maryland

Patient Name: _____ DOB: _____

I hereby consent to the release of any and all hearing, language, and speech records for the individual named above to:

Name / Agency: Patient

Address: _____

_____

Name / Agency: _____

Address: _____

_____

This information pertains to assessment and treatment by the Hearing and Speech Clinic, University of Maryland, College Park.

Signature: _____ Date: _____

Name: _____

Relationship To Patient _____

Witness: _____

FOR CLINIC USE ONLY – REPORTS TO BE MAILED

Report(s)	Reports(s) Date	Supv. Sig.	Sent	Sec

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Notification of Use of Protected Health Information for Fundraising Purposes

We hope you appreciate the wonderful service you receive from our clinic! We would like to be able to reach out to you in the future both to evaluate your experiences here, and to be a supporter of the clinic. This would allow us to continue providing these valuable services to others in the community who need them.

With that in mind, this form is a courtesy notification to inform you that the administrative staff of the University of Maryland Hearing and Speech Clinic within the Department of Hearing and Speech Sciences and associated development officers of the College of Behavioral and Social Sciences may use your contact information (which constitutes protected health information) for fundraising purposes **in support of the University of Maryland Hearing and Speech Clinic ONLY.**

The health information that we may use for fundraising purposes includes:

- Patient demographic data (name, address, phone/email, date of birth, age, gender, etc)
- Dates of patient services
- General type of department from which the patient/client received services (Speech or Hearing)
- Information about the clinical faculty who supervised your services

This information will only be used to identify and contact you regarding opportunities to support the University of Maryland Hearing and Speech Clinic.

The health information that we will not use or disclose are as follows:

- Health insurance status
- Outcome information
- Diagnosis
- Nature of services
- Treatment

If you do not wish to receive any fundraising information from the University of Maryland Hearing and Speech Clinic, it is your right to opt out of any and all solicitations. If you wish to opt out, please check to box below and provide your name and date; otherwise thank you for your time and consideration.

☐ I do NOT wish to receive fundraising information from the University of Maryland Hearing and Speech Clinic.

Printed Name: _____

Signature: _____ Date: _____