Bloom Speech Therapy
3370 Brae Bourn Drive, Huntingdon Valley, PA, 19006
jenica@bloomspeechtherapy.net
215-870-9768

Consent for Services

☐ I authorize Bloom Speech Therapy to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Bloom Speech Therapy in writing. In addition, Bloom Speech Therapy may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding Bloom Speech Therapy rendering evaluation and therapy services to the client named below.

_____ _____
Print Name of Client Date

_____
Client Date of Birth

_____ _____
Signature of Client or Legal Representative Relationship to Client

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Consent for Observation

I, _____, (client or parent/guardian name) hereby grant

Bloom Speech Therapy and their consultants, contractors or employees to observe

_____ (client name) in the following setting(s):

Name of Location

☐ Day Care _____

☐ School _____

☐ Work _____

☐ Other _____

☐ I understand that during this observation, Bloom Speech Therapy, their consultants, their contractors, or their employees may speak to providers, clinicians, teachers, employers, etc. about the client and I thereby grant permission for such discussions.

I am the client, parent or legal guardian of the person named below and have the legal authority to provide consent for observation.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____

Home Address: _____

_____

I, _____(client or family member) hereby grant Bloom Speech Therapy permission to communicate with the following person or agency:

Name:_____

Contact Information:_____

_____

Information to Be Released:
☐ Medical History
☐ Therapy Evaluation
☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ Treatment Notes
☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ School Records (Evaluations, IEP, academic reports, etc.)
For the Purpose Of: (check all that apply)
☐ Coordinating care with other professionals
☐ Providing continuity of services
☐ Updating therapeutic progress
☐ Other _____
☐ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.
☐ I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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Consent and Release of Photographs / Videos

☐ I, _____(client or parent/guardian name) give consent to Bloom Speech Therapy or any party authorized by Bloom Speech Therapy to photograph and/or video record _____ (client name) in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.

☐ I authorize Bloom Speech Therapy to use pictures of _____ (client name) for promotional purposes (ex. brochures, website, etc.)

☐ I acknowledge that I will receive no financial compensation for providing consent since my participation with Bloom Speech Therapy in providing my consent and release is voluntary.

☐ I hereby release Bloom Speech Therapy, their contractors, their employees and/or any third parties involved in the creation or publication of Bloom Speech Therapy. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

☐ I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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Communication Preference Form

Client Name: _____ Date of Birth: _____

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to Bloom Speech Therapy to do the following:

Written Documentation and Verbal Information

☐ I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email provided.

☐ I grant permission to provide me with written communication via unencrypted email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication via USPS in an unmarked envelope.

☐ I elect to receive clinical information in person or via telephone through the number provided.

☐ I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

Sharing of Information

Individual's Name	Relationship to Client	Email Address and/or Phone Number
1.		
2.		

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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Caregiver Questionnaire Form

CHILD INFORMATION

Date:_____

Child's Name: _____

Caretaker's Name:_____

Caretaker's relationship to the child:_____

_____

Days/Times child is in your care:_____

_____

_____

Caregiver's address:_____

_____

How long has this child been under your care?_____

Describe the child's strengths:_____

_____

_____

_____

_____

_____

Describe any difficulties the child has had under your care: _____

_____

_____

_____

_____

_____

Describe any strategies you have found useful in supporting the child's weaknesses:___

ACADEMIC SKILLS

Please comment on the child's basic concept skills:

- Shape Concepts:
- Color Concepts:
- Number Concepts:
- Ability to Match (colors, shapes, sizes, pictures, objects, etc.):
- Letter Concepts:
- Additional:

BEHAVIOR SKILLS

Please discuss this child's behavior for the following areas:

- Compliance to Rules and Routines:
- Activity Level:
- Following Directions/Attention to Task:
- Social - Emotional Skills:

- Peer Relationships:_____

_____

- Play Skills:_____

_____

- Self Help Skills (dressing, feeding, toileting): :_____

_____

- Fine Motor Skills (writing, cutting, zippers):_____

_____

- Gross Motor Skills (walking, running, jumping, climbing):_____

_____

- Sensory Aversions/Enjoyments (e.g. child does not enjoys 'messy' play, loud noises, certain tastes or textures; child enjoys movement - swings, running, rocking, sucking on objects, etc.):_____

_____

LANGUAGE COMPREHENSION - LISTENING

Do you have any concerns regarding the child's listening skills? □Yes □No

Describe:_____

Does the child follow directions independently? □Yes □No

Describe:_____

What level of directions can the child follow independently? For example: 1-step (e.g. 'put your toys away'), 2-step (e.g. 'put your toys away and get your shoes') or 3-step directions (e.g. 'put your toys away, get your shoes and put on your jacket) _____

_____

Please indicate if child can answer the following questions correctly:

Who? □Yes □No
What? □Yes □No
Where? □Yes □No
Why? □Yes □No
When? □Yes □No
How? □Yes □No

Does the child appear to understand you when talking to him/her? _____

_____

Does the child demonstrate understanding of the following concepts:

'big, little' □Yes □No
'in, out' □Yes □No
'on top, under' □Yes □No
'In front, behind' □Yes □No

EXPRESSIVE LANGUAGE - SPOKEN LANGUAGE

Does the child typically communicate with single words 1-2 words, 3-4 word, 5+ words in an utterance?:_____

_____

Does the child ask Who, What, Where, When, Why questions?:_____

_____

_____

Does the child use grammar markers correctly, e.g. correct word order, uses plural /s/, verb tenses '-ing, -ed', pronouns (e.g. I, you, he, she, it, they), possessives (e.g. my, yours, his, her)?:_____

_____

_____

Is the child's spoken language seem on par with his/her peers? □Yes □No

Describe:_____

SOCIAL USE OF LANGUAGE

Does the child independently make his/her needs known? □Yes □No

Describe:_____

Does the child request toys/objects from caregiver/peers? □Yes □No

Describe:_____

Does the child verbally respond to caregiver/peer questions? □Yes □No

Describe:_____

Does the child verbally use greetings? □Yes □No

Describe:_____

How does the child protest?_____

Does the child use language/gestures to gain caregiver/peer attention? □Yes □No

Describe:_____

Doe the child point to objects/actions in order to direct attention? □Yes □No

Describe:_____

Does the child take conversational turns talking with caregiver/peers? □Yes □No

Describe:_____

Does the child initiate conversations? □Yes □No

Describe:_____

Does the child primarily respond to questions but does not initiate or carry on a conversation with caregiver/adult? □Yes □No

Describe:_____

Does the child direct caregiver to perform different actions with his/her spoken language? □Yes □No

Describe:_____

Do you have any questions regarding autism spectrum disorder in relation to this child? □Yes □No

Describe:_____

SPEECH SOUND PRODUCTIONS - INTELLIGIBILITY

How well do you understand the child?

□ Less than 25%
□ Less than 50%
□ 75%-80%
□ 90% or more
□ Other -

Does the child ever express frustration or appear upset regarding not being understood? □Yes □No

Describe:_____

Do you have concerns regarding the child's speech sound productions (articulation - e.g. 'd' for 'g', 'w' for 'r')? □Yes □No

Describe:_____

_____

FLUENCY (STUTTERING) -

Do you have any concerns regarding the child speech fluency (stuttering)?:

□Yes □No

Describe:_____

Does the child exhibit any of the following:

Halting speech? □Yes □No

Describe:_____

Repetition of whole words (e.g. why, why, why, why)? □Yes □No

Describe:_____

Part-word repetitions (e.g. be-be-b-because)? □Yes □No

Describe:_____

Prolongations of single sounds (e.g. IIIIIIIIII want to go)? □Yes □No

Describe:_____

Extraneous body movements when trying to talk through a stutter? (E.g. facial grimacing, tapping of fingers, waving of hands). □Yes □No

Describe:_____

SPEECH RATE - PROSODY

How would you describe the child's rate of speech? Slow, normal, fast?:_____

_____

How would you describe the child's prosody/intonation of speech? Do they raise their voices at the end of a sentence to indicate they are asking a question? :_____

_____

Does the child speak fluidly and smoothly? □Yes □No

Describe:_____

Does the child's speech sound halting or 'robotic'? Do they frequently take a breath mid-sentence? □Yes □No

Describe:_____

VOCAL QUALITY - RESONANCE - BREATHING

How would you describe the child's typical vocal quality? E.g. does the child's voice often sound normal/raspy/scratchy/rough?_____

_____

Does the child often sound congested (like they have a cold)? Do you ever hear air escaping through their nose when speaking? □Yes □No

Describe:_____

_____

Does the child frequently shout or make loud play sound effects when playing?:

□Yes □No

Describe:_____

Do you observe the child to frequently breath with an open mouth posture?

□Yes □No

Describe:_____

Please indicate when you have observed the child to have an open mouth posture:

When seated at table? □Yes □No
When playing? □Yes □No
When doing arts/crafts? □Yes □No
When listening to stories? □Yes □No
During nap-time? □Yes □No

Does the child frequently have colds/runny noses/allergies? □Yes □No

Describe:_____

Does the child snore during nap-time? □Yes □No

Describe:_____

FEEDING SKILLS

Can the child feed himself/herself independently? □Yes □No

Describe:_____

Is the child a messy eater □Yes □No

Describe:_____

Is the child a slow/fast eater ? □Yes □No

Describe:_____

Does the child overstuff mouth when eating? □Yes □No

Describe:_____

Does the child avoid eating/drinking certain foods/drinks during meal times?:

□Yes □No

Describe:_____

Does the child frequently cough when eating/drinking or after eating/drinking?

□Yes □No

Describe:_____

Do you have any concerns regarding the child's safety with eating skills? □Yes □No

Describe:_____

PLAY SKILLS

Does the child enjoy playing with peers?: □Yes □No

Describe:_____

What are the child's favorite toys/activities to play with?:_____

_____

Does the child play independently near peers? □Yes □No

Describe:_____

Does the child play with same toys next to peers (e.g. both students are playing with blocks next to each other)? □Yes □No

Describe:_____

Does the child play interactively with peers with same toys (e.g. both students engage in building a tower with blocks together)? □Yes □No

Describe:_____

Does the child engage in imaginative/pretend play with peers (e.g pretending to be a parent taking care of a baby)? □Yes □No

Describe:_____

Does the child play with toys appropriately (e.g. uses a shovel for digging, can stack blocks to make a tower)? □Yes □No

Describe:_____

Does the child pretend objects are something else during play (e.g. pretends a stick is a sword, a block is a car, etc.)? □Yes □No

Describe:_____

Does the child engage in a variety of play schemas (variation in play) or do they typically play the same way/same schema each day? □Yes □No

Describe:_____

If you have any additional comments to share regarding this child please do so below:

_____

_____

_____

_____

_____

_____

Thank you for your time filling out this form.

Your input is a valuable part of this child's evaluation.

If you have any questions or concerns not mentioned in this questionnaire or need additional clarification, please don't hesitate to reach out to:

Jenica Andic, M.S. CCC-SLP at 215-870-9768.