Outreach/Therapy Information Sheet

Child's Name:____ Birth Date:____________________

In the event that we need to communicate with you during the day, please rank your preferred method of communication in the spaces provided below, with "1" being the primary mode of communication:

ADULT 1:		ADULT 2:	
Name:		Name:	
Address:		Address:	
City/Zip:		City/Zip:	
Cell Phone:		Cell Phone:	
Text OK? ☐ Yes ☐ No	List Carrier:	Text OK? ☐ Yes ☐ No	List Carrier:
Work Phone:		Work Phone:	
Email:		Email:	

Family: Please list all persons living in the household(s) with the child. Please provide ages of other children in the home:

Name	Nickname	Relationship	Sex	Age

COLLABORATION INFORMATION:

Pediatrician's Name:	Pediatrician's Phone #:
School Name and Address:	
Teacher Name:	Teacher Email:
Speech Language Pathologist Name:	Speech Language Pathologist Email:
Hearing Itinerant Name:	Hearing Itinerant Email:
Audiologist Name:	Audiologist Email:
Name/Role of Other Members of the Team:	Other Members Email:

*If accessing the sliding scale, please attach most recent tax return to this intake packet so that we can determine your rate. Sign below to acknowledge receipt and agreement with the therapy tuition billing policy.

Signature:	Signature:

I/we plan to: ☐ Enroll in Tuition Express ☐ Make monthly payments by check

Office Use Only: Assigned Rate per Session__________________________

CARLE AUDITORY ORAL SCHOOL