NORTH MEMORIAL HEALTH

12000 Elm Creek Blvd # 210
Maple Grove, MN 55369
Phone: (763) 581-9100
Fax: (763) 581-9101

INTENSIVE COGNITIVE-COMMUNICATION PROGRAM
Application

All information will be considered confidential

Date_____

APPLICANT INFORMATION			
Name			
Nickname			
Date of Birth	Age	SS# - -	Gender ☐M ☐F
Address			
City	State	Zip Code	
Home Phone ( )	Work/Alternate Phone ( )		
Cell Phone ( )	Email Address		
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner			
Do you need an interpreter? ☐ Yes ☐ No If yes, what kind?			
What is your ethnicity? ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Prefer not to say			
What is your race? ☐ White ☐ Black/African American ☐ Asian ☐ Native American/Alaska Native ☐ Native Hawaiian/Pacific ☐ Prefer not to say			
What is your religious preference?			

PHYSICIAN INFORMATION		
Physician's Name	Clinic	
Address		
City	State	Zip Code
Phone ( )	Fax ( )	
Neurologist's Name	Clinic	
Address		
City	State	Zip Code
Phone ( )	Fax ( )	

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EMERGENCY CONTACT / NEXT OF KIN			
Emergency Contact:		Relationship to Patient:	
Home Phone ( )	Work/Alternate Phone ( )	Cell Phone ( )	
Street Address	City	State	Zip Code
Next of Kin:		Relationship to Patient:	
Home Phone ( )	Work/Alternate Phone ( )	Cell Phone ( )	
Street Address	City	State	Zip Code

INSURANCE INFORMATION		
Does your insurance policy require prior authorization? ☐ Yes ☐ No		
Primary Insurance:		
Member ID #:	Group #	Effective Date:
Subscriber Name (name on card):		
Subscriber ID #:	Subscriber Date of Birth:	
Subscriber Social Security #: - -	Subscriber Employment Status:	
Subscriber Employer:	Subscriber Employer Phone Number:	
Subscriber Employment Address:		
City	State	Zip Code

Secondary Insurance:		
Member ID #:	Group #	Effective Date:
Subscriber Name (Name on card):		
Subscriber ID #:	Subscriber Date of Birth:	
Subscriber Social Security #: - -	Subscriber Employment Status:	
Subscriber Employer:	Subscriber Employer Phone Number:	
Subscriber Employment Address:		
City	State	Zip Code

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EDUCATIONAL HISTORY							
Check highest grade completed in school	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12
Did you attend a university? ☐ Yes ☐ No				Degree received:			
Is English your native language? ☐ Yes ☐ No							
How would you rate your English proficiency? ☐ Poor		☐ Fair		☐ Good/Native		☐ Superior	
Were you ever fluent in any other foreign language? ☐ Yes ☐ No If yes, what language?							

EMPLOYMENT HISTORY	
Current or Most Recent Occupation	Employer
Are you still employed? ☐ Yes ☐ No	
If no, are you on a leave of absence? ☐ Yes ☐ No	How long?

PERSONAL CARE	
Are you on any special diet? ☐ Yes ☐ No	If yes, please describe
Do you have any allergies? ☐ Yes ☐ No	If yes, what are they?
Do you regularly use a wheelchair ☐ Yes ☐ No	If yes, are you independent in all transfers? ☐ Yes ☐ No
How far can you go independently (walking or wheelchair)? ☐ 25 yards or less ☐ 25 – 50 yards ☐ 50 – 100 yards ☐ 100 yards or more	

SPEECH/LANGUAGE EXAMINATION/THERAPY			
Agency 1:	Phone: ( )		
Street Address	City	State	Zip Code
Dates:			
Agency 2:	Phone: ( )		
Street Address	City	State	Zip Code
Dates:			

SPEECH AND LANGUAGE HISTORY		
Did you have any speech or hearing problems before this illness/accident occurred?	☐ Yes	☐ No
If yes, describe:		
Is there any history of speech, language or hearing problems in your family?	☐ Yes	☐ No
Preferred dates of attendance		

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COGNITIVE - COMMUNICATION SKILLS		
How do you speak, primarily? (check one) ☐ Single words ☐ Phrases ☐ Sentences		
Can you follow conversation?	☐ Yes	☐ No
Do you understand what you read?	☐ Yes	☐ No
Can you fill out forms?	☐ Yes	☐ No
Do you have trouble remembering things?	☐ Yes	☐ No
Do you have trouble following daily routines? (e.g., basic hygiene, taking medications, etc.?)	☐ Yes	☐ No
Are you able to follow a daily schedule?	☐ Yes	☐ No
Are you able to complete a task when distractors are present? (e.g., Are you able to prepare a meal while the television is turned on?)	☐ Yes	☐ No
Are you able to resume a task following a distraction? (e.g., If you are cooking and you receive a phone call, can you take the call and resume cooking?)	☐ Yes	☐ No
Do you use your non-preferred hand when writing, drawing, and/or completing other activities of daily living?	☐ Yes	☐ No
What do you want to achieve from the Intensive Cognitive-Communication Program?		
What is your goal?		

ADDITIONAL INFORMATION
If you have seen a speech-language pathologist at any point during the last year, please ask your therapist to complete the enclosed **SLP Referral Form**.
All applicants, please have your doctor complete the enclosed **Medical Information Form.**

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INTENSIVE COGNITIVE-COMMUNICATION PROGRAM
Medical Information Form

APPLICANT INFORMATION		
Patient Name		
SS# - -	Date of Birth	Date of Injury

Mechanism of Injury (please circle and provide details below):

Brain Injury Chemobrain Concussion

CVA Other _____

Please specify type/location of injury (e.g., R CVA, SDH, SAH, Brain tumor, etc.)

Other Conditions (please circle):

Chemical dependency Mental illness Other:

Chronic headaches Dementia

Does the patient have visual deficits as a result of the injury? ☐ Yes ☐ No

If yes, please specify (e.g., neglect, field cut, diplopia, etc.)

Dietary Restrictions:

Date of last completed physical/neurological exam:

Do you feel your patient would be physically capable of participating in an intensive speech-language program? ☐ Yes ☐ No

Would your patient require any medical monitoring during therapy? ☐ Yes ☐ No

If yes, please describe:

PHYSICIAN ORDERS

I recommend that this patient receive evaluation and treatment for cognitive-linguistic deficits by Speech- Language Pathology at North Memorial Health.

Physician's Signature

Physician's Name (please print)

Street Address	City	State	Zip
Phone ( )	Date		
Fax ( )	Physician's UPIN #		

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INTENSIVE COGNITIVE-COMMUNICATION PROGRAM
Speech-Language Pathologist Referral Form

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APPLICANT INFORMATION		
Patient Name		
Date of Birth		

SPEECH-LANGUAGE PATHOLOGIST INFORMATION			
SLP Name:			
Phone: ( )	Fax: ( )		
Agency:	City	State	Zip Code
Dates:	Frequency of Therapy:		

Please fax completed SLP Referral Form along with patient speech records to North Memorial Health's Intensive Cognitive-Communication Program at (763) 581-9101.

Records may include any recent documentation, such as a progress report, daily note, or discharge summary.

Speech-Language Pathologist's Signature	Date

If there is any information you would like us to know regarding this applicant, please include it here.
You are also welcome to contact us via phone at (763) 581-9100. Thank you.