NORTH MEMORIAL HEALTH

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

PEDIATRIC INTENSIVE SPEECH PROGRAM

Application

All information will be considered confidential

Date_____

APPLICANT INFORMATION			
Child's Name			
Date of Birth	Age	SS# - -	Gender ☐M ☐F
Address			
City	State	Zip Code	
Home Phone ( )	Work/Alternate Phone ( )		
Cell Phone ( )	Email Address		
Do you need an interpreter? ☐ Yes ☐ No If yes, preferred language:			
What is your child's ethnicity? ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Prefer not to say			
What is your child's race? ☐ White ☐ Black/African American ☐ Asian ☐ Native American/Alaska Native ☐ Native Hawaiian/Pacific ☐ Prefer not to say			
What is your religious preference?	What country was your child born in?		

EMERGENCY CONTACT			
Emergency Contact #1	Relationship to Applicant		
Home Phone ( )	Work/Alternate Phone ( )		
Street Address	City	State	Zip Code
Emergency Contact #2	Relationship to Applicant		
Home Phone ( )	Work/Alternate Phone ( )		
Street Address	City	State	Zip Code

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

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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	

GUARANTOR				
Is the subscriber listed above the person responsible for the bill? ☐ Yes ☐ No If yes, skip this section.				
Guarantor Name		Relationship to Applicant		
Street Address		City	State	Zip Code
Date of Birth	SS# - -		Gender ☐M ☐F	
Home Phone ( )		Work/Alternate Phone ( )		
Employer		Employer Phone Number		
Employment Street Address		City	State	Zip Code

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SPEECH THERAPY INFORMATION			
Does your child receive speech therapy through the school district? ☐ Yes ☐ No			
School Speech Therapist Name	Phone: ( )		
Dates:			
Does your child receive private/outpatient speech therapy services? ☐ Yes ☐ No			
Outpatient Speech Therapy Clinic	Phone: ( )		
Street Address	City	State	Zip Code
Dates:			
OCCUPATIONAL THERAPY INFORMATION			
Does your child receive occupational therapy through the school district? ☐ Yes ☐ No			
School Occupational Therapist Name	Phone: ( )		
Dates:			
Does your child receive private/outpatient occupational therapy? ☐ Yes ☐ No			
Outpatient Occupational Therapy Clinic	Phone: ( )		
Street Address	City	State	Zip Code
Dates:			
SPEECH/LANGUAGE SKILLS			
Does your child use words to communicate? ☐ Yes ☐ No			
Does your child combine words in speech? ☐ Yes ☐ No			
What is the average length of phrase your child uses? ☐ 2 words ☐ 3 words ☐ 4 or more			
What percentage of your child's speech do you understand?			
What percentage of your child's speech do other adults understand? (e.g., teacher, relatives, etc.)			
Is your child aware of his/her problem? ☐ Yes ☐ No			
Is there any history of speech, language or hearing problems in your family? ☐ Yes ☐ No			
If yes, who and what type of problem?			

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MEDICAL INFORMATION

Was your child born full-term? ☐ Yes ☐ No If no, how many weeks gestation?

Were there any complications during pregnancy or delivery? ☐ Yes ☐ No

If yes, please describe:

Have there been any hospitalizations or surgeries since birth? ☐ Yes ☐ No

If yes, please list reason and dates:

Does your child require a special diet? ☐ Yes ☐ No

If yes, please describe:

Does your child have any allergies? ☐ Yes ☐ No

If yes, please describe:

Does the patient have a history of any of the following:

☐ Asthma	☐ Head injury	☐ Attention deficit disorder
☐ Ear infections	☐ Tonsillectomy	☐ Learning disabilities
☐ Hearing loss	☐ Adenoidectomy	☐ Anxiety
☐ Seizures	☐ Cleft palate	☐ Depression

Please explain any items checked above:

Please list any other related diagnosed conditions that would be helpful for us to know:

SOCIAL HISTORY

Sibling's Name(s) Age(s)

What are your child's interests?

What are your child's motivators?

GOALS

What do you want your child to achieve from the Pediatric Intensive Speech Program?