MONTCLAIR STATE UNIVERSITY

Center for Audiology & Speech Language Pathology 1515 Broad Street, 2nd Floor
Bloomfield, NJ 07003
Voice: (973) 655-6917
Fax: (973) 655-7072
email: csdclinic@montclair.edu

PEDIATRIC APPLICATION

Thank you for inquiring about the Center for Audiology & Speech Language Pathology at Montclair State University. The Center offers assessment and treatment for children and adults with communication disorders or differences including, but not limited to, the following areas: articulation, expressive and receptive language, voice, stuttering, aphasia, traumatic brain injury, and accent modification.

The Center is part of the training for graduate students in the Master of Arts program in speech/language pathology. Services are provided by graduate students who are supervised by licensed and certified speech/language pathologists. Therapy is provided on a semester basis including an eleven week summer program. Therapy begins at the onset of the semester in January, May, and September. Therapy sessions are typically 50 minutes in duration. Individual and group therapy sessions are available and are determined based on a client's needs and availability within the Center. All services are only available in English.

HOW TO APPLY

Applications to the center are accepted on a continuing basis. However, new clients are only accepted into the program at the start of each semester (January, May, and September). **When your application is received, you will be placed on a waiting list and contacted when an opening at the center becomes available.** Speech and Language evaluations are done by appointment throughout the year.

DESCRIPTION OF SERVICES

The clinical program at the Center for Audiology & Speech Language Pathology demonstrates a variety of innovative assessment and intervention modes. After completion of an intake interview, an evaluation plan is proposed, which may include the following:

Consultation

Speech and Language Evaluation
To assess the status of language development, articulation, fluency, voice or neurogenic language impairment.

Speech and Language Therapy

Note: *Financial assistance may be available to those who qualify, please contact the center for more information. Individual or small group intervention for the remediation of communication disorders provided on a per-semester basis. Please call the Center for current fees.*

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GENERAL INFORMATION

THE INFORMATION THAT YOU PROVIDE REGARDING YOUR CHILD'S MEDICAL, DEVELOPMENTAL AND ACADEMIC HISTORIES WILL HELP US PROVIDE APPROPRIATE SERVICES. ***PRIOR TO THE ONSET OF SERVICES, AN EVALUATION DATED WITHIN THE LAST 12 MONTHS MUST BE RECEIVED.*** EVALUATIONS MAY BE COMPLETED AT THE **CENTER FOR AUDIOLOGY & SPEECH LANGUAGE PATHOLOGY** OR ELSEWHERE. APPLICANTS WHO DO NOT ATTACH A REPORT WILL BE CONTACTED TO ARRANGE AN EVALUATION.

Application Date: _____

Last Name: _____ **First Name :** _____

Age: _____ **Gender:** ☐ Male ☐ Female **DOB:** _____

Street Address: _____ **Apt/Unit:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **E-mail Address:** _____

Business Phone: _____ **Parent Name(s):** _____

Cell Phone: _____ **Referred By:** _____

Describe any allergies or reactions: _____

_____

Language(s) spoken in the home: _____

_____

If parents are divorced, please indicate legal custodial status of child: _____

_____

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EDUCATION INFORMATION

Current School: _____ **Current Grade Level:** _____

Street Address: _____ **Suite/Unit:** _____

City: _____ **State:** _____ **Zip Code:** _____

Name(s) of Previous School(s)	Grade Level(s)	Date(s)	Reason For Leaving

SPEECH AND LANGUAGE COMMUNICATION

Please describe the nature of your child's communication and the concerns that brought you to the Center for Audiology & Speech Language Pathology:

Describe anything special or different about your child's motor, physical, academic, social, or emotional development:

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SPEECH AND LANGUAGE COMMUNICATION

Has your child received speech/language therapy in the past?

If yes, where? What areas were addressed in therapy?

Describe any hospitalizations, accidents, serious illnesses, or medications:

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If your child has been evaluated, please fill out the appropriate information below:

TYPE OF SCREENING	BY WHOM	DATE	RESULTS
HEARING			
PSYCHOLOGICAL			
NEUROLOGICAL			
EDUCATIONAL			
SPEECH & LANGUAGE			
OTHER (nutritional, allergy, occupational therapy)			

PLEASE ATTACH ANY SPEECH/LANGUAGE DIAGNOSTIC REPORTS PREVIOUSLY COMPLETED. ALSO ATTACH RECENT IEP OR IFSP (IF APPLICABLE).

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SEMESTER INFORMATION

THE INFORMATION THAT YOU PROVIDE IN THIS SECTION IS REGARDING YOUR SEMESTER PREFERENCES FOR FUTURE SCHEDULING UPON ACCEPTANCE INTO THE PROGRAM. NEW CLIENTS ARE ONLY ACCEPTED INTO THE PROGRAM FOR THERAPY AT THE START OF EACH SEMESTER (JANUARY, MAY, AND SEPTEMBER). WE WILL DO OUR BEST TO MEET ALL REQUESTS, BUT CERTAIN TIME SLOT AVAILABILITY IS LIMITED.

PLEASE CHECK ANY TIME SECTION IN WHICH THE CLIENT IS GENERALLY AVAILABLE TO RECEIVE THERAPY

WHICH SEMESTER ARE YOU GENERALLY AVAILABLE:

☐ **FALL** (September-December) ☐ **SPRING** (January-April) ☐ **SUMMER** (May-August)

☐ **ANY SEMESTER** (I would like to be considered for every semester)

HOW MANY DAY(S)/TIME(S) PER WEEK WOULD YOU WOULD LIKE SPEECH THERAPY:

☐ 1x/week ☐ 2x/week

☐ **ONE SESSION PER WEEK**	☐ **TWO SESSIONS PER WEEK**
☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday**	☐ **Monday/Wednesday** ☐ **Tuesday/Thursday**
☐ Morning (9am -11:30am) ☐ Afterschool (2pm – 3:30pm)	☐ Morning (9am -11:30am) ☐ Afterschool (2pm – 3:30pm)
☐ Afternoon (12pm -2pm) ☐ Evening (4pm – 5pm)	☐ Afternoon (12pm -2pm) ☐ Evening (4pm – 5pm)
☐ Other:_____	☐ Other:_____

E-mail to: csdclinic@mail.montclair.edu

Mail to:
Center for Audiology & Speech Language Pathology
Montclair State University
1515 Broad Street, Building B, 2nd Floor
Bloomfield, NJ 07003

PLEASE CONTINUE TO THE NEXT PAGE FOR THE STATEMENT OF UNDERSTANDING.

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STATEMENT OF UNDERSTANDING

The Center for Audiology & Speech Language Pathology is an integral part of the teaching and research programs of Montclair State University. Substantially, all services at the Center are performed by graduate students working under the supervision of the qualified faculty and clinical associates. Evaluations and tutorial sessions with children and conferences with their parents are, from time to time, observed by students through one-way mirrors, or recorded on video or audio tape for future discussions by groups of students and their instructors at the University. For this reason, the Center can accept, for service only, those clients who are willing to cooperate with the educational and research activities of the Center, as indicated above. Applicants may be assured that such activities will in no way interfere with the quality of services provided:

I have read the above statement and agree:

a) These services may be rendered to me or my child by graduate students, faculty, and clinical associates.

b) That the sessions in which I and/or my child participate may be viewed by students at the Center, or may be recorded on audio or video tape and used in connection with the teaching and research programs of the Center, including presentations at professional meetings.

SIGNATURE (PARENT OR GUARDIAN MUST SIGN IF APPLICANT IS A MINOR) *DATE*

For Internal Use Only		
Date Received:	Faxed: _____ Emailed: _____ Mailed: _____ Client Delivered: _____	Notes:

_____ Manager Signature (If Applicable)	_____ Director Signature Date

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USE OF STUDENT CLINICIANS

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I have read the above statement and agree:

a) that services may be rendered to me or my child by both graduate students, faculty, and clinical associates.
b) that sessions in which I and/or my child participate may be viewed by students at the Center, or may be recorded on audio or video tape and used in connection with the teaching and research programs of the Center, including presentations at professional meetings.

_____
Signature

(Parent/Guardian must sign if applicant is a minor)

_____
Date