We are pleased that you contacted our program for evaluation services. Enclosed you will find:

1. Map with directions to our clinic
2. Case History questionnaire

Please keep this letter and map for future reference.

Return items 2 and 3; completed Case History questionnaire and Permission for the evaluation to:

Clinic Coordinator
Speech and Hearing Clinic
University of Central Oklahoma
100 N. University Drive
Edmond, OK 73034

Only when these items have been received by us can we set up a file and contact you to make an appointment. Appointments will be scheduled in order of receipt and availability of student clinicians. Keep in mind that we follow a fourteen-week fall and spring semester and a seven-week summer semester schedule. If you send us the completed case history form after or during a particular semester, it may be several weeks before you are contacted to arrange the appointment. Be assured that we will reach you as soon as possible.

The night before your appointment, the student clinician assigned to your evaluation will contact you to confirm this appointment. The clinician may at that time also wish to clarify any information provided on the forms. If you have copies of current educational or medical information pertaining to your communication concerns, it would be helpful if you could either send them with the above forms or bring them with you to the evaluation.

The evaluation may include assessment of the understanding and use of the English language, the clarity of speech, voice and fluency and hearing acuity. The evaluation will be performed by a graduate student clinician under the supervision of a faculty member that is certified by ASHA, the American Speech-Language-Hearing Association. The evaluation may also be observed by other students in the program. Confidentiality of your records and the evaluation session are always held in strictest regard.
If the client to be evaluated is a child, and they have questions about the procedure, you might very honestly and simply explain that he/she will get to wear earphones and listen to some little sounds. We require that parents remain at the clinic during the entire evaluation period.

The typical length of evaluation process is between 2 and 3 hours. Immediately following the evaluation, the results of the tests and recommendations will be discussed with you in person. A formal written evaluation report will be mailed to you approximately one month following the evaluation. If you wish for us to send a copy to another source, you will need to sign a Release of Information Form from UCO which is available at our clinic.

Our STANDARD fee schedule is as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech-Language-Hearing Evaluation</td>
<td>$150.00</td>
</tr>
<tr>
<td>Hearing Evaluation</td>
<td>$ 50.00</td>
</tr>
<tr>
<td>Therapy Fall and Spring Semester (approx. 14 weeks)</td>
<td>$350.00</td>
</tr>
<tr>
<td>Therapy Summer Semester (approx. 7 weeks)</td>
<td>$175.00</td>
</tr>
</tbody>
</table>

The full payment for the evaluation is expected immediately following the appointment. Written reports will not be available until full payment is received.

Persons who receive state financial assistance or who attend or who are employed by UCO are eligible for a reduced fee. Please indicate in the space provided on page 2 of the Case History form if you would like us to send you an application for reduced fee.

Thank you for providing this opportunity for us to serve your communication needs. We look forward to hearing from you.

Linda Sealey-Holtz, PhD, CCC-S  
Program Director  
405-974-5297

Elaine Martindale, MS, CCC-S  
Clinic Coordinator  
405-974-5403
UNIVERSITY OF CENTRAL OKLAHOMA
SPEECH AND HEARING CLINIC
ADULT CASE HISTORY

Name ___________________________ Birthdate ______________ Male ____ Female ____ Date ____________
Address _____________________________________________ City __________________  Zip ____________
Home Phone ______________________ Other phones ______________________  ______________________
Person completing this form______________________________ Relation to client ______________________
Referred by ______________________________ Primary Physician _________________________________
Client’s Birthplace ______________________ Last grade completed / degree ______________________
Occupation __________________________ Last place of employment ____________________________
Hobbies/Interests ____________________________________________
Languages spoken ________________________________________________________________________
Persons currently residing in your home ______________________________________________________
Other significant family members or friends __________________________________________________
Check areas of difficulty or concern:
SPEECH ______ pronunciation of words ______ chewing ______ swallowing
LANGUAGE ______ understanding spoken language ______ formulating meaningful sentences
____ understanding written language ______ writing meaningful sentences
VOICE ______ too loud ______ too quiet RATE ______ too fast ______ too slow
COGNITION ______ memory ______ attention ______ problem solving ______ math calculations
HEARING  ____ conversations in crowds  ____ telephone ring  ____ outdoor noises

Which ear do you currently wear hearing aids  ____ left  ____ right; Date began wearing ______________

Describe family history of hearing loss __________________________________________________________
_________________________________________________________________________________________

VISION – Describe any visual limitations and history wearing corrective lenses or corrective surgery
_________________________________________________________________________________________
_________________________________________________________________________________________

Describe any serious injuries or illnesses, which may relate to the speech, language or hearing concern
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Locations and dates of previous speech-language-hearing therapy ___________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Describe any physical limitations or assistance needed by our staff __________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

List current medications _____________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Persons currently receiving state financial assistance or who are either attending or employed by UCO may be eligible for reduced fee status.

Check here if you would like an application for reduced fees  ____ YES  ____ NO
PERMISSION FOR SPEECH-LANGUAGE-HEARING EVALUATION / TREATMENT

I, _________________________________, give permission to the University of Central Oklahoma Speech & Hearing Clinic to evaluate and/or treat the speech, language and hearing of _________________________________, BIRTHDATE_________________.

This program provides professional training at the undergraduate and graduate levels. The evaluation and any subsequent treatment may be performed by students supervised by licensed faculty of the Speech-Language Pathology Program. I further understand that these services may be observed by students in training for degrees in Speech-language Pathology at the University of Central Oklahoma.

All records pertaining to evaluation and treatment will be held for SEVEN years following discontinuation of services in this facility.

____________________________________  
Client / Parent or Guardian

____________________________________  
Date Signed