Associate Name: Discipline:

Your e-mail:

Phone: Date:

CONSULTATION REQUEST FORM

Please maintain **HIPAA compliance,** including using a secure, not shared, e-mail &
send completed form to **librarian@integratedlistening.com**;
SUBJECT LINE: **iLs Supervision Request – (1-3 descriptive words)**
Please be specific in your **typed** responses below.

If inadequate information is provided your request will be delayed, and you will be asked for more information regarding your client. Please refrain from using acronyms on this form.

PSEUDONYM: DATE OF BIRTH: AGE: GRADE: GENDER:

JOB/OCCUPATION:

PRESENTING PROBLEM: (the main reason this individual came to your clinic)

DEVELOPMENTAL DELAY: (speech, motor delays; crawling, walking, speaking, balance, coordination)

SIGNIFICANT PAST HISTORY: (birth history, prior assessments, treatments/interventions and results, losses - direct and indirect, moves, etc.)

SIGNIFICANT MEDICAL ISSUES: (illnesses, all medications - including dosages, allergies, injuries, surgeries)

CURRENT CONCERN: (reason **you** are seeking supervision)

iLs PROGRAM HISTORY: (Program history and # of sessions, including times per week. AC setting(s)? BC setting(s)? Which program/session are they on now? At which session(s) were changes reported? What has happened since?)

WHAT DO YOU THINK IS OCCURRING?

Please use the section below (next pg.) **for any additional details and questions regarding this client.**

Email completed form to librarian@integratedlistening.com