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| Associate Name: | Discipline: |
| Your e-mail: | Date: |
| Phone: |  |

**SSP CONSULTATION REQUEST FORM**

Please maintain **HIPAA compliance,** including using a secure, not shared, e-mail.   
Send completed form to [**librarian@integratedlistening.com**](mailto:librarian@integratedlistening.com) with the   
subject line: **SSP Supervision Request – (1-3 descriptive words)**

Please be specific in your **typed** responses below.  
*If inadequate information is provided your request will be delayed, as we await additional   
information regarding your client. Please refrain from using acronyms on this form.*

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| PSEUDONYM: | DATE OF BIRTH: | GRADE: |
| JOB/OCCUPATION: | AGE: | GENDER: |

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| **PRESENTING PROBLEM** The main reason this individual came to your clinic |
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| **DEVELOPMENTAL DELAY** Speech, motor delays; crawling, walking, speaking, balance, coordination |
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| **SIGNIFICANT PAST HISTORY** Birth history, prior assessments, treatments/interventions and results, losses - direct and indirect, moves, etc. |
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| **SIGNIFICANT MEDICAL ISSUES** Illnesses, all medications - including dosages, allergies, injuries, surgeries |
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| **CURRENT CONCERN** Reason **you** are seeking supervision |
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| **SSP HISTORY** Which hours of SSP have been completed? At what rate? Is this the first round of SSP? At which session(s) were changes reported? What has happened since? |
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| **WHAT DO YOU THINK IS OCCURRING?** |
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| **ADDITIONAL DETAILS** Please include any additional details and questions regarding this client |
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