Hearing Clinic
Phone: (813) 974-8804
Fax: (813) 905-9819
Email: hearingclinic@usf.edu

Directions to the USF CSD Hearing and Speech-Language Clinics

**Please do not use the mailing address: ~~4202 Fowler Ave.~~

Building Address: 3711 USF Laurel Dr, Tampa, FL 33612

From I-275 (Downtown Tampa or Airport Area)

Exit I-275 to Fletcher Avenue (exit 52)
Drive east on Fletcher Avenue, past Bruce B. Downs Blvd. to Magnolia Drive
Turn right on Magnolia Drive and drive south
Turn left at 2nd traffic light onto Citrus Drive - opposite Moffitt Cancer Center
Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

From I-75 (from Areas North, South, or East of Tampa)

Take Fletcher Avenue (exit 266) and drive west to Magnolia Drive
Turn left on Magnolia Drive (at light) and drive south
Turn left at 2nd traffic light, Citrus Drive - opposite Moffitt Cancer Center
Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

Fowler Avenue Entrance

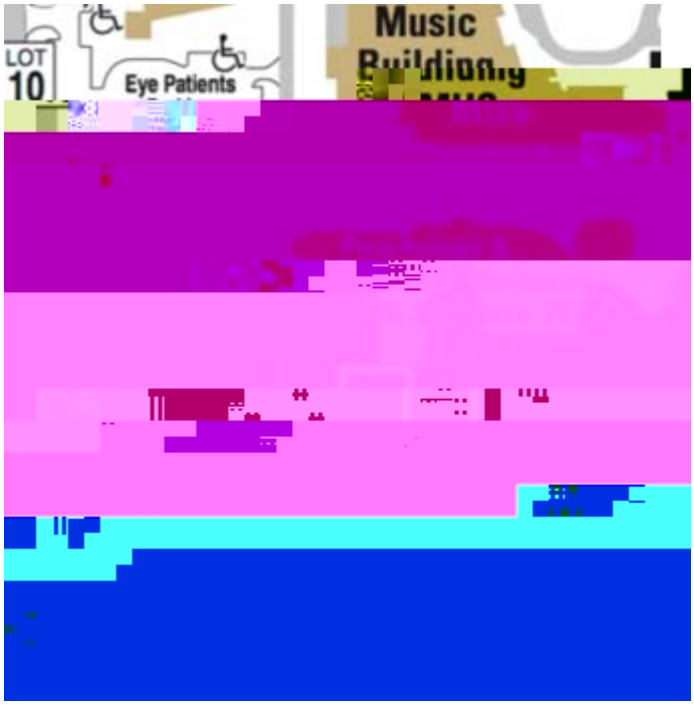
Turn onto Leroy Collins Blvd. into USF campus main entrance
Turn left at 1st stop light onto Alumni Drive
Turn right onto Magnolia Drive
Turn right onto Citrus Drive - opposite Moffitt Cancer Center
Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

Parking at USF CSD Hearing and Speech-Language Clinics

Please park in the reserved spots marked PSY/CSD in Lots 9A or 46.
Please display RED clinic parking pass on dashboard.

Lot 9A

Lot 9A is located past the building on the Left (assigned reserved parking spaces are closest to the Psychology Building). When you exit your car, you will want to head back to the CSD Building which will be on your left.



UNIVERSITY OF SOUTH FLORIDA
HEALTH & BEHAVIORAL SCIENCES

Speech and Language Clinic
(813) 974-9844
Fax (813) 905-8928

UNIVERSITY OF SOUTH FLORIDA
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS
SPEECH, LANGUAGE, HEARING CENTER - PCD 1017
TAMPA, FLORIDA 33620-8150
Language: (813) 974-9844
Fax: (813) 974-0822

PHOTO

Audiology: (813) 974-8804

PRE-EVALUATION CASE HISTORY FORM FOR CHILDREN

PLEASE READ CAREFULLY

Enclosed are several forms which MUST [redacted]

Name of Client: _____
Last First Middle

Ethnicity (optional)
☐ Asian/Pacific Islander ☐ Caucasian ☐ [redacted] ☐ [redacted]
☐ [redacted]

DOB:_____ Gender (optional): ☐ Male ☐ Female

Address:
City State Zip

Language(s) spoken by client: Primary language spoken in home:

Father: Age: _____ Education:

Address: Phone (home):

Cell Phone: Email address:

Occupation: Place of Employment:

Phone:

Marital Status: ☐ [redacted]

Mother: Age: _____ Education:

Address: Phone (home):

Cell Phone: Email address:

Occupation: Place of Employment:

Phone:

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Care Physician:

Address:

Phone:

Referred by:
Name Address Zip
Person to contact in case of emergency:
Relationship; Phone:

Person Completing Questionnaire:
Relationship to Client:

Other Children in Family:
Name:
Age:
Gender:

Have there been any other pregnancies? ☐ Yes ☐ No If yes, explain:

If child has been diagnosed as having any of the following, please check those that pertain:

☐ Cleft Palate ☐ Cerebral Palsy ☐ Mental Retardation ☐ Visual Impairment ☐

[redacted]

Please indicate below which of the examinations or treatment the child has received [redacted]

What where the APGAR ratings at the time of birth? 1st 2nd Birth weight

HEALTH AND MEDICAL HISTORY

What is your child's present health condition? (Excellent) 1 2 3 4 5 (Poor)
Present weight Height
When, where and with whom your child was's most recent medical examination·

Please check all immunizations the child has received: Small Pox Diphteria Mumps Measles Rubella

Does you child have any feeding difficulties? If yes, please describe:
Does your child have strong food preferences? If yes, please explain:
Does your child have any food allergies? If yes, please explain:

MOTOR DEVELOPMENT

At what age did your child sit alone? Stand up? Begin walking?

Who provided it?
What type is it?

Has the teacher indicated any hearing problem in class? ☐ Yes ☐ No
Please include any other information pertaining to hearing you feel may be of importance to us.

SCHOOL HISTORY

Did your child attend daycare/preschool? Yes No

USF SLHC Patient and Caregiver Policies

Client Name: _____ DOB: _____

Parking:

1. Your parking permit should be visible and you should only park in designated areas.

Caregivers/Parents/Guardians present during sessions:

2. Per USF (legal counsel) policies, for parents/guardians of minors, parents/guardians must be on-site while the patient is in our facilities.
3. For caregivers of adults with no ability to communicate immediate wants and needs, caregivers must be on-site while the adult patient is in our facilities OR the adult patient must have in his/her possession the contact information for us to reach the caregiver.

Tardiness, Attendance and Sick Policy:

4.

®

HEALTH

CONSENT TO TREATMENT AND CARE OF MINORS

In my absence, I, _____ ,hereby
Parent / Legal Guardian

give consent for medically necessary treatment and care, including emergency treatment, to

_____ , by health care providers
Child's Name

affiliated with the University of South Florida/USF Physicians Group.

Signature of Patient/Legal Guardian *Date*

Witness *Date*

Emergency Phone Numbers

Mother: _____ Home:
Name Work:

[redacted] _____ Home:
Name Work:

Legal Guardian: _____ Home:
Name Work:

Patient's Name:

Medical Record #:

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

Speech and Language Clinic
(813) 974-9844
(813) 905-8928 – FAX

[redacted]

HEALTH

Patient Name: MRN Number:

As a result of the American Recovery and Reinvestment Act, the USF Physicians Group is required to collect patient data regarding race, ethnicity and language as part of information provided to the Centers for Medicare & Medicaid Services (CMS)

[redacted]

___ American Indian/Alaska Native

___ Asian

___ Black

___ [redacted]

___ White

___ Declined

___ Unknown

Ethnici

___ Hispanic or Latino or Spanish Origin

___ Not Hispanic or Latino or Spanish Origin

___ Declined

___ Unknown

Please note that [redacted]

Language

[redacted]

Preferred Method of Notification _____

BY: *(Initials)*

USF CSD Speech
Hearing and
Bolesta Center Clinics

I voluntarily consent to any Medical Care that may be considered necessary

C. I have been informed that the USF Health does not have a contract to participate with my insurance plan or HMO, and/or the requested Medical Care has not been authorized by my insurance plan/HMO, as applicable. I am requesting Medical Care as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

I expressly agree and consent that, in order for USF Health or its employees, agents or affiliates to service my account (including debt collection and payment purposes) USF Health, or any of its employees, agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. USF Health, or any of its employees, agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails using any e-mail address or phone number I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device.

I acknowledge that I have been provided a copy of the USF Health Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement

USF Speech and Language Clinic

Treatment Scheduling, Wait List, and Provider Assignment Policies

Evaluation does not guarantee treatment

A completed Speech and Language evaluation is not guarantee[illegible] in the [redacted]

Wait List for Treatment

Following Speech and Language evaluation, you or your child might be placed on a wait list for treatment. An estimate of the wait time cannot be provided as it depends on provider and clinical instructor availability. If you are interested in receiving treatment at another facility, please notify us.

Providers, Clinical Instructors, and Students

Since this is a training facility, providers, clinical instructors and students work in our clinic. At any point [redacted]

Patient Name

Patient DOB

Patient/Caregiver (if patient is under 18) Signature **Date**

Patient MRN