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| **DEAR PARENTS,** |
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| Within the time constraints of our 10-day stay in Switzerland, we are offering four service delivery options: ***screening***, ***assessment***, ***consultation***, and ***intensive therapy course***. Below you will find detailed description of each option, including its goals, frequency, duration, outcome and cost. Please choose what is appropriate and desirable for you by checking off the appropriate box, sign the form and email it to [firstrowe.sftc@gmail.com](mailto:firstrowe.sftc@gmail.com) before May 15, 2018. If you are not sure intervention is necessary, you may sign up for a screening or assessment – you do not have to make a decision regarding treatment at this time. However, if you already know that your child’s condition needs intervention and you are interested in therapy, please notify us ASAP, preferably before May 11th. That way, we can reserve you a spot and better prepare for the course.  Looking forward to meeting you and your child,  ../../../../Downloads/new%20doc%202017-12-22%2003.07.51_1.  Natalia Rowe,  M.S., CCC-SLP, TSSLD  Clinical Director & Diagnostic Supervisor  FirstRowe Speech & Feeding Therapy Center |
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| **DIAGNOSTICS**  **SCREENING** |
| * DESCRIPTION: Typically, one or two short measures of your child’s communication skills. * DURATION: 20 to 30 minutes. * MEASURES: Informal and/or formal screening tools, such as professional observation, parent/teacher consultation, checklists, and standardized screeners. * OUTCOME: *recommendation for full evaluation*, *monitoring of child’s development*, *referral to other professional*, and/or *functioning within normal limits*. * COST: $90, which will be applied to evaluation fee if full evaluation is recommended.   \_\_\_\_ I would like my child to be **screened** in areas related to the following concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **ASSESSMENT** |
| * DESCRIPTION: A comprehensive evaluation using one or more formal assessments to measure your child’s communication skills across one or more areas (e.g., expressive language, articulation, and/or pragmatics). * DURATION: 1 to 1.5 hours. * MEASURES: Informal (professional observation, parent/teacher consultation, checklists) and/or formal assessment tools (standardized tests, criterion-referenced tests). * OUTCOME: *discussion of assessment results and clinical recommendations.* * COST: $150/hr, $25 per each additional 25-min interval.   \_\_\_\_ I would like my child to be **assessed** in areas related to the following concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **CONSENT FOR SCREENING/ASSESSMENT:**  We hereby consent for FirstRowe Speech Pathology, P.C., to ☐ **screen** or **☐ evaluate** our child as indicated above.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DATE OF BIRTH |

FULL NAME OF CHILD

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PARENT/GUARDIAN SIGNATURE DATE

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| **TREATMENT**  **CONSULTATION** |
| * DESCRIPTION: Consultation may follow an in-depth evaluation or be conducted separately when the speech/feeding/developmental problem has previously been identified. * DURATION: 45 to 60 minutes. * OUTCOME: *based on the assessment results and/or the nature of parental concerns, the family will be provided with information about the causes and structure of child’s speech-language, feeding/swallowing or social/pragmatic issues. Family will receive guidance regarding further steps that may include referrals to medical professionals, advise on appropriate educational setting, ideas on how to modify child’s environment to enhance learning, as well as evidence-based re/habilitation strategies and techniques to be implemented by family members and therapeutic team.* * COST: $120 per 45min, $150 per 1hr, $25 per each additional 25-min interval.   \_\_\_\_ I would like to receive a **consultation** related to the following concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **INTENSIVE THERAPY COURSE** |
| * DESCRIPTION: This format of speech service delivery was initially designed to boost skill acquisition in children with severe speech motor disorders (e.g., apraxia, poor speech intelligibility), developmental conditions (e.g., autism), and feeding disorders (e.g., severe food refusal, picky eaters). Over the past 5 years, we have successfully used this model to provide much-needed support to the long-distance families who we visited in their home country or who came to our clinic from other parts of the US, Canada, Russia, Israel, Croatia and Holland. If necessary, Skype sessions may be provided as a follow-up. * DURATION/FREQUENCY: 30-, 45- or 60-minute sessions 1-2 times/day every day or based on the evaluator’s recommendations and child’s availability. * OUTCOME: *the course involves both direct therapy provided to the child and training/consults provided to family members. Parents participate in the development of a treatment program, observe and practice therapy the implementation of therapeutic techniques. Corrective feedback is provided. By the end of the course, parents are typically prepared to follow through with the program. The therapist is available via Skype when they need further guidance or a refresher.* * COST: $150/hr, $25 per each additional 25-min interval.   \_\_\_\_ I would like my child to be **assessed** in areas related to the following concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **CONSENT FOR SCREENING/ASSESSMENT:**  We hereby consent for FirstRowe Speech Pathology, P.C., to provide ☐ **consultation** or **☐ intensive treatment course** to our child as indicated above.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DATE OF BIRTH |

FULL NAME OF CHILD

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PARENT/GUARDIAN SIGNATURE DATE

Thank you for taking the time to complete this information about your child.

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PARENT/GUARDIAN SIGNATURE DATE