Riley Hospital for Children
Indiana University Health

Pediatric Birth to Three Therapy Questionnaire

To be completed if child is not enrolled in school, but receives therapy.

Return to:
Francia Ware
Indiana University Cochlear Implant Program
Riley Hospital
705 Riley Hospital Drive
Room 0860
Indianapolis, IN 46202
Phone: 317-944- 6671
Fax: 317-944-6680
fware@iuhealth.org

Dear Parent or Guardian:

Please sign below and forward to your child's Speech/ Developmental and/or Early Intervention Therapist to complete.

I authorize the school teachers and other staff members to provide the information requested in this form to the cochlear implant team at the above address.

(Signed) Parent or Guardian _____ ***Date:*** _____

Child's Name: _____ DOB: _____

Services Provided:

_____
Developemental Therapy (Began / Frequency / Terminated, if applicable)

_____
Speech Therapy (Began / Frequency / Terminated, if applicable)

_____
Occupational Therapy (Began / Frequency / Terminated, if applicable)

_____
Physical Therapy (Began / Frequency / Terminated, if applicable)

_____
Other: Please Describe

Vision Screening:
Date: _____ Age: _____ Result: _____

If the student requires glasses, are they worn? _____

What is the child's primary mode of communication? _____

Is it used in the home? YES NO **Is it used by all family members?** YES NO

What communication mode used in therapy? _____

Is it used in the home? YES NO **Is it used by all family members?** YES NO

Therapy Attendance:

Number of Sessions Missed: _____

Reason? _____

Are there any particular concerns regarding this child's progress?

Have you discussed this with the parents?

Do you feel the parents share your concerns?

What specific information do you desire regarding the child and how we might be of help to you? Please add any other information regarding this child that you feel might be helpful with our evaluation.

Thank you!

Person(s) completing this report & role regarding this child:

Name:_____ Role: _____

Name:_____ Role: _____

Name:_____ Role: _____

Name:_____ Role: _____

Date_____