California State University, Los Angeles
Department of Communication Disorders

CLINICAL PHILOSOPHY

The Department of Communication Disorders at CSULA embraces a philosophy of clinical service delivery that is consistent with the ethical standards, scope of practice, and current standards of practice of the American Speech-Language-Hearing Association (ASHA). Our goal is to serve individuals with communication disorders in the most effective and humane manner possible, and to ensure that our students commit themselves to this fundamental clinical value. In training our students, we emphasize the importance of holding paramount the well-being of clients as well as their families and caregivers. The importance of involving families and caregivers in all aspects of the therapeutic process is also stressed.

SERVICES OFFERED

At the Robert L. Douglass Speech-Language Clinic we provide a full range of diagnostic and therapeutic services in a university environment. We offer services for both children and adults with articulation, phonology, language, cognitive, voice, fluency, and hearing disorders. Individual and group therapy services are available in both Spanish and English. Our clinic has also received a grant from the Parkinson Voice Project® to implement SPEAK OUT! ® and the LOUD Crowd® therapy programs.

THE STAFF

All services are provided by graduate student clinicians who are supervised by faculty and clinic staff members holding California licensure and the American Speech-Language-Hearing Association's Certificate of Clinical Competence.

FEES

All services are provided free of charge.

THE ROBERT L. DOUGLASS SPEECH-LANGUAGE CLINIC

comd@calstatela.edu

Phone: (323) 343-4754

Fax: (323) 343-4698

http://www.calstatela.edu/hhs/comd/department-communication-disorders-robert-l-douglass-speech-and-language-clinic

At the Robert L. Douglass Speech-Language Clinic we provide a full range of diagnostic and therapeutic services in a university environment. Our clients include adults, preschoolers, and school-aged children with a variety of communication disorders. We do not discriminate on the basis of race, color, national origin, disability, sex, gender, or sexual orientation.

The clinic is part of a graduate degree program that is accredited by the Council on Academic Accreditation (CAA). As such, we maintain high standards in the provision of comprehensive assessment and intervention services.

To request an application or make additional inquiries, please call the Clinic Office at (323) 343-4754. The Clinic is open from 9am to 6pm Monday through Thursday, and 9am to 4pm on Friday. The Clinic is located in the basement level of King Hall (B119) on the CSULA campus adjacent to Parking Lot 8 on Circle Drive. Free parking is provided.

CALIFORNIA STATE UNIVERSITY, LOS ANGELES

Department of Communication Disorders
5151 State University Drive
Los Angeles, CA 90032
(323) 343-4754 or 343-4690

Confidential

DATE: _____

THE ROBERT L. DOUGLASS SPEECH-LANGUAGE CLINIC

CASE HISTORY FORM – ADULT

Client: _____ Sex: M ☐ F ☐

Date of Birth: _____ Age: _____ Marital Status: M ☐ S ☐ D ☐ W ☐

Place of Birth:_____

Home Address: _____ _____ _____
Number/Street City Zip

Home Phone Number:( ) _____

Work Phone Number: ( ) _____

Cell Phone Number: ( ) _____

If you check your email daily and it is OK for us to contact you this way, fill in your address below:

_____

Name of person completing this form if other than the client: _____

Relationship to client:_____

Name of person who referred you to this clinic: _____

Professional position:_____

PRIMARY CONTACT PERSON(S) (if not the client)

1. Name: _____

   Relationship to client:_____

   Cell phone number: (_____)_____ Work phone number: (_____)_____

   If you check your email daily and it is OK for us to contact you this way, fill in your address below:

   _____

2. Name: _____

   Relationship to client:_____

   Cell phone number: (_____)_____ Work phone number: (_____)_____

   If you check your email daily and it is OK for us to contact you this way, fill in your address below:

   _____

REFERRAL INFORMATION

State the client's reasons for consulting the Speech-Language Clinic. Include a description of the client's communicative and/or cognitive (e.g., memory, attention, concentration) difficulties with as much detail as possible.

_____

_____

_____

_____

_____

_____

Has the client had previous speech, language, hearing, or vision testing? Yes ☐ No ☐

If yes, describe (include where, when, and diagnosis): _____

_____

_____

Has the client had previous speech, language, hearing, or vision therapy? Yes ☐ No ☐

If yes, describe (include where and when): _____

_____

_____

LANGUAGE PROFICIENCY

Primary Language of Client: _____

Other Language(s) Spoken:

_____ Level of Proficiency: _____

_____ Level of Proficiency: _____

_____ Level of Proficiency: _____

HOME INFORMATION

List all persons currently living in the client's home:

Name	Relationship to Client	Age	Gender

EDUCATION/OCCUPATION

Highest grade completed: _____

Are you currently attending college? Yes ☐ No ☐

If yes, where? _____

What is your current occupation? _____

Name of Employer: _____

If currently unemployed or retired, what was your previous occupation?

_____

MEDICAL/HEALTH INFORMATION/HISTORY

Name of Physician: _____ Phone Number: ( ) _____

Address: _____ _____ _____
Number/Street City Zip

List operations and serious illnesses and injuries. Give dates and length of disability.

Illness, Injury or Operation	Date	Description

Does the client currently have a physical disability? Yes ☐ No ☐

If yes, describe (e.g., use of a wheelchair, cane, etc.): _____

_____

Is the client under any medication at present time? Yes ☐ No ☐

If yes, what medication(s) (include dosage and frequency)? _____

_____

_____

Note: Please include/attach most recent relevant medical report(s), if applicable.

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ROBERT L. DOUGLASS SPEECH AND LANGUAGE CLINIC

PRIVACY NOTICE AND CONSENT FORM

The Robert L. Douglass Speech and Language Clinic is a training service agency. Our services to clients are provided by students who are supervised by faculty members. In order to provide this supervision and promote student learning through observation, our clinic rooms have special equipment – one-way observation windows, TV monitors, and audio and/or video recording devices. Occasionally a video or audiotape will be saved beyond the time of direct services because it is considered a good example for training purposes. These tapes are subject to all the confidential restrictions mentioned below.

Keeping client information confidential and secure, and using it only as our clients would want us to, is a top priority for all of us at the Robert L. Douglass Speech and Language Clinic. Here, then, is our promise to our clients and their families:

1. We will safeguard, according to strict standards of confidentiality and security, any information that clients share with us. What is discussed as part of the therapy process is confidential unless and until you give consent to its release.
2. We will permit only authorized employees, students, and instructional staff who are trained in the proper handling of client information to have access to that information.
3. We will not reveal client information to any external organization unless we have previously informed the client in disclosures or agreements, have been authorized by the client to share the information, or are required by law to reveal that information.
4. We will always maintain control over the confidentiality of our client information.

In short, any personal information that we collect about you or your family will be protected by physical, electronic, and procedural safeguards that meet or exceed applicable law. Finally, information obtained from clients may be used for research purposes. If this occurs, information will be handled professionally, treated confidentially, and any identifying information about the client is removed.

I have read the above policy statements and agree to these conditions.

_____	_____
Signature of Client	Signature of Parent or Legal Guardian
_____	_____
Print Client's Name	Date