Shirley Ryan AbilityLab
Intensive Aphasia Therapy Program Application

Physician Medical Information Form

Patient Name: _____

Date of birth: _____ Date of last physical exam: _____

Etiology (Diagnosis) of communication impairment: _____

Date of onset: _____

Current medications, dosage and frequency: _____

_____

_____

_____

Allergies: _____

Other conditions:

☐ Diabetes	☐ Heart disease	☐ Seizures
☐ Depression	☐ Hypertension	☐ Syncope
☐ Chronic headaches	☐ Hemiparesis	☐ Visual field deficits

Dietary restrictions: _____

_____

Do you recommend that your patient participate in an intensive speech-language program?

☐ YES ☐ NO

Would your patient require medical monitoring if involved in our program?

☐ YES ☐ NO

If yes, please describe. _____

_____

Additional information that might be pertinent to your patient's participation in our intensive speech-language program. _____

_____

This patient is approved for outpatient speech therapy 5-6 hours a day 5 days a week.

Physician signature: _____

Physician Name (Print): _____

Address: _____

Phone: _____

Email: _____ Date: _____