St Luke's HOSPITAL & Health Network

Evaluation Procedures

1. Upon your arrival, please check in at the front desk and you will be directed to our secretary. Please be sure to bring the following:

    a. Insurance cards and/or HMO referral from your primary care physician (if required by your insurance company)
    b. Prescription from the doctor

2. The evaluation will last approximately 1 hour.

3. Due to the nature of the evaluation, it is advisable to keep other children at home.

4. If your child is not feeling well (i.e., has an ear infection, respiratory infection, etc.) it would be best to reschedule your appointment, as the child may not participate fully in the evaluation process. You can contact the department at 484-526-3200 to reschedule.

5. If a hearing screening or evaluation has also been scheduled, please note that there is a separate charge for these procedures. If you have any questions regarding that service, please contact the Audiology Department at 484-526-3201.

Thank you for choosing the Pediatric Rehabilitation Department at St. Luke's North.

ST. LUKE'S NORTH - PEDIATRIC REHABILITATION
INITIAL INTAKE FORM

___Occupational Therapy ___Physical Therapy ___Speech Therapy ___ Feeding

Client Name:	**DOB:**
Parent(s) Name:	
Address:	
Home Phone:	**Physician:**
Work Phone:	**Specialists:**
Cell Phone:	
Dominant Language:	**Referral Source:**

PRIMARY CONCERNS:

Diagnosis: ☐ Yes ☐ No If yes,

Medical Complications: (Hearing Loss, Tubes, Seizures, Etc.)

Clinical History:

Previous Eval? ☐ Yes ☐ No If yes, where?

Previous/Current Therapy? ☐ Yes ☐ No If yes, where?

Request Reports. **Rec'd** ☐ Yes ☐ No

Insurance:

Primary:

Secondary:

**** Remind patient he/she will need prescription for PT/OT or anything insurance requires; also, bring insurance cards to evaluation.***

Date Completed:

OVER ➡

If for speech treatment, has child had hearing eval in last 6 months? ☐ **Yes** ☐ **No**

If yes, where?

Results? **(Send/fax copy of results)**

If not, please request to schedule

Date:

Packet mailed? ☐ **Yes** **Date:** **Initials:**

Packet returned on:

TODAY'S DATE: ***TAKEN BY:***

Contact:

Evaluation Scheduled: **Date:** **Time:**

Therapist: