HMS ASSOCIATES
SPEECH, LANGUAGE AND FEEDING THERAPY

Phone Intake Form

Today's date _____ **Town** _____

Name of child _____

Parent name _____

Age of child _____ **DOB** _____

Phone _____

Email _____

Referral source / Pediatrician _____

Current diagnosis _____

Therapy type: Speech / Feeding / Language / other (Orofacial Myology)

Other information; ie primary concern, prior therapy

_____

_____

_____

_____

_____

_____

_____

_____

Consult scheduled _____

Paperwork emailed _____ **Paperwork received:** Intake - Hist - CC _____ HIPAA _____

Confirmed consult _____ Park Ridge Florham Park