Shirley Ryan AbilityLab

Center for Aphasia Research & Treatment
355 East Erie Street, Chicago, IL 60611 | 312.238.6163 | sralab.org

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

Dietary restrictions: _____

_____

Do you recommend that your patient participate in an intensive comprehensive aphasia 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 comprehensive aphasia program. _____

_____

This patient is approved to attend the Shirley Ryan AbilityLab Intensive Aphasia Program; 6 hours a day, 5 days a week.

Physician signature: _____

Physician name (print): _____

Address: _____

Phone: _____

Email: _____ Date: _____