**Communication Improvement Program**
*Institute for Stuttering Treatment and Research*
*An Institute of the Faculty of Rehabilitation Medicine, University of Alberta*

# TEEN & ADULT APPLICATION FORM

***Please complete all appropriate sections or your application will be returned for completion.***

Name: ______________________________________________ Birthdate: ____________________
*(day/month/year)*

Sex: F ❑ M ❑ Another/prefer not to disclose ❑ Age: ______

Address: ______________________________________________________________________

City: ___________________________ Province: _____________ Postal Code: ________________

Phone (home): ______________________________ (work): ___________________________
*(include area code)* *(include area code)*

Preferred Contact Method: ____________________ E-mail address: ___________________________

How did you hear about us? ________________________________________________________

**PARENTS OR GUARDIANS** **– complete this section only if client is under 18 years of age.**

Relationship to child, if Guardian: ____________________________________________________

| | | Mother | Father |
|---|---|---|---|
| Name: | | ________________ | ________________ |
| Address (if different: than above) | | ________________ | ________________ |
| | | ________________ | ________________ |
| Education: | | ________________ | ________________ |
| Phone | (home): | ________________ | ________________ |
| | (work): | ________________ | ________________ |
| | (cell): | ________________ | ________________ |
| Fax: | | ________________ | ________________ |
| E-mail: | | ________________ | ________________ |

Why are you seeking assessment and/or treatment? **(Response required)**: ___________________________

_______________________________________________________________________________

Name and contact information of individual making referral *(if applicable)*: _______________________

_______________________________________________________________________________

Please list all related assessment and therapy that have been provided:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Do you have concerns about your accent? Yes ❑ No ❑

If yes, please note languages spoken ___________________________________________

Do you have concerns about your clarity of speech? Yes ❑ No ❑
Do you have concerns about your ability to communicate with others? Yes ❑ No ❑
Do you have concerns about your voice? Yes ❑ No ❑
Do you have concerns about your ability to produce sounds? Yes ❑ No ❑
Do you have concerns about your expressing yourself verbally? Yes ❑ No ❑
Do you have concerns about your ability to understand spoken communication? Yes ❑ No ❑

Additional information that you feel will help us understand your communication difficulty better:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Please indicate which services are required:
Assessment ❑
Treatment ❑
Assessment and Treatment ❑
CIP Workshop ❑
Location: Edmonton ❑
Calgary ❑
Distance ❑

**SIGNATURE OF APPLICANT:** ______________________________ Date: ________________
(Signature of parent or guardian if applicant is under 18) *(day/month/year)*

***Please email completed form to:*** istar@ualberta.ca

*Or fax it to:* (780) 492-8457

*Or send it to:* ISTAR
8205 114 St, 3-48 Corbett Hall
Edmonton, AB Canada T6G 2G4

Applying for treatment shows your consent to being contacted occasionally via email about current course offerings (refreshers or workshops, etc), and occasional paid programs and events. As always, you can unsubscribe from a particular email mailing list at any time by clicking the unsubscribe link on those emails.

**Protection of Privacy -** The personal information requested on this form is collected under the authority of Section 33 (c) of the *Alberta Freedom of Information and Protection of Privacy Act* and will be protected under Part 2 of that *Act*. It will be used in a confidential manner, for the purpose of delivering speech therapy services and for providing updates and information about ISTAR. Direct any questions about this collection to: ISTAR, 8205 114 St, 3-48 Corbett Hall, Edmonton, AB Canada T6G 2G4. Phone: (780) 492-2619. Email: **istar@ualberta.ca**