DEPARTMENT OF COMMUNICATIVE DISORDERS, CSULB
CLIENT STATUS FORM

Name: ___________________ Phone Number: __________ Date: ______
Contact Person: ___________ Phone Number: __________ Cell: __________
Current Semester: ___________ Number of Semesters in Therapy: __________

Current Clinic: _______________ Color of File: _______________
Does the client need to be moved to a different clinic? ______ Yes ______ No
If yes, please mark all that apply (Please indicate the most appropriate clinic with a star):
___ Child-Adolescent Speech & Language (A) ___ Autism Spectrum Disorders (B)
___ Clinical Practice-Special Programs (H) ___ Adult Speech and Language (J)
___ Clinical Practice with Culturally and Linguistically Diverse Clients (L)

Does the client wish to return: ______ YES ______ NO
Diagnosis: ________________________________
Recommendation to enroll/return to clinic: _____ YES _____ DISCHARGED
On the scale of 1 to 3, please indicate priority level:
____ 1 (high priority) _____ 2 (middle) _____ 3 (low priority)
Explain: ____________________________________________________________

When would the client wish to return: _____ Fall _____ Spring _____ Summer

Please indicate any general comments here:
________________________________________________________________________

If client is a child please include their school schedule: ___________________________________________________________________

Are they bilingual or exposed to a second language: ______ YES ______ NO
What language: ______________
If so, is an interpreter needed: ______ YES, When: _______________ ______ NO

CALL LOG

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Clinician Name: ____________________________ 4/4/2016