Mass General Brigham
Newton-Wellesley Hospital

Newton-Wellesley Hospital Rehabilitation Services

Thank you for contacting us about your child's speech and language evaluation. As we may have discussed on the telephone, we will need the following information completed and returned to us as soon as possible before we can schedule an evaluation appointment for your child:

- **Completed and signed Pediatric Speech-Language Pathology History Form**
- **Copies of any previous speech, language, hearing and learning evaluations**
- **Copies of IEPs or 504 Educational plans**
- **If your child is not yet registered as a patient at NWH, or if you have any new insurance changes, please call our Patient Service Center prior to scheduling at 855-890-9241**

Once we receive this information from you, we will then contact you to schedule your child's appointment. Please note that new patient evaluations are typically scheduled at 9 AM for approximately 2 hours on Tuesdays, Thursdays, and Fridays.

We look forward to working with your family to address your concerns about your child's communication abilities. If you have further questions, please contact the Pediatric Speech Department at **617-243-6172**.

Please send a completed copy to **NWHRehabPediSpeech@partners.org**, fax it to **617-243-6651** or mail the form to the following address:

> **Newton-Wellesley Hospital**
> **Attn: Pediatric Speech and Language Department Speech Therapy Intake Appt.**
> **159 Wells Avenue**
> **Newton, MA 02459**

Sincerely,

Newton-Wellesley Hospital Rehabilitation Services

Name: ______________________

Date of birth: ______________________

Date: ______________________

Pediatric speech and language pathology history form

Child's full name: ______________________ Birth date: ______________________

Home phone: ______________________ Work: ______________________ Cell: ______________________

Address: ______________________

Email: ______________________ Zip Code: ______________________

Insurance Name: ______________________ Insurance #: ______________________

Subscriber's name: ______________________ Subscriber's birth date: ______________________

Person completing form: ______________________ Today's date: ______________________

Relationship to child: ______________________

Parent name: ______________________ Age: ______ Occupation: ______________________

Parent name: ______________________ Age: ______ Occupation: ______________________

Pediatrician: ______________________ Phone: ______________________ Fax: ______________________

With whom does your child live: ______________________

Siblings (names and ages): ______________________

Languages spoken in the home: ______________________

How did you hear about us? ______________________

Description of the problem:

What do you hope to learn from this evaluation?

____

Please describe your child's speech-language or learning problems:

____

When did you first become aware of the problem:

____

How has the problem changed since you first became aware of it:

____

Are there situations where the problem seems worse and/or better:

____

Pregnancy and birth history:

Were there any difficulties during pregnancy? Explain: ______________________

____

Length of pregnancy: ______________________ Birth Weight: ______________________ Apgar Score: ______________________

Were there any difficulties during labor? Explain: ______________________

____

Were there any feeding, sucking, swallowing, or sleep difficulties during infancy?

Explain: ______________________

Name: ______________________________

Date of birth: ________________________

Medical history

Does your child have any medical diagnoses? Please list:

____

Is your child taking any medications? Which ones and for what?

____

List any serious illness, surgeries, or accidents with dates:

____

Did your child have any ear infections as a toddler? If so, how many?

____

How were the infections treated? (Antibiotics, tube placement, other)

____

Date and place of your child's most recent hearing test and the results:

____

Date and place of your child's most recent vision examination and the results:

____

Are immunizations up-to-date? ____

Developmental history – at what age did the following occur:

Sat alone: ____________________ Stood Alone: ______________ Walked unaided: ____________

What hand does the child prefer: ______ Bowel trained: ______________ Bladder trained: ____________

Babbled (repeated consonant plus vowel production): ______________________________

First word: ____________________ Example: ________________

Estimated current vocabulary size: ____________________________

Combined two words: ____________________ Example: ______________________

First sentences: ________________________ Example: ______________________

Do you have any concerns about your child's feeding or swallowing? If so, please describe:

____

Educational and treatment history

Was your child involved in early intervention or any other early special services? Please list type of services provided and frequency: ____

____

Has your child had previous speech and language, neuropsychological, educational, etc. evaluations and/or treatment? If so, please list below and describe the nature of any intervention. ______________

____

Speech and language evaluations:

Date: ________________________ Location: ______________ Results: ______________

Is report attached? ______________

Describe treatment (include type, frequency and duration):

____

Name: ______________________________

Date of birth: ________________________

Neuropsychological evaluations:

Date: ______________________ Location: ______________ Results: ______________

Is report attached? ______________

Describe treatment (include type, frequency and duration):

____

Academic/educational evaluations:

Date: ______________________ Location: ______________ Results: ______________

Is report attached? ______________

Describe treatment (include type, frequency and duration):

____

Early intervention evaluations:

Date: ______________________ Location: ______________ Results: ______________

Is report attached? ______________

Describe treatment (include type, frequency and duration):

____

Daycare/playgroups/preschool attended by your child:

____

Educational information:

Current school: ________________ Grade: ________ Number of children in class: ____________

Do you have any concerns about your child's academic performance? If so, please describe:

____

Has your child ever received special services in school? Please describe type, frequency and duration:

____

Social history:

Please describe your child's play habits/skills/interests:

____

Does your child get along with peers? Explain:

____

Do any immediate or extended family members have a history of speech, language, learning or mental health problems? If so what is their relationship to the child (Uncle, sister, etc.)? What were their difficulties?

____

Additional information:

____

____

Signature of parent, guardian or other legal representative Date:

____

Printed name

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Insurance Coverage for Speech and Language Therapy Services

Thank you for choosing Newton-Wellesley Outpatient Rehabilitation Services for you or your family's rehabilitation needs. Our mission is to provide you with the same care we would for a beloved family member. The purpose of this notice is to help you, the member, better understand your benefits and coverage for speech and language therapy and to help you determine whether services at Newton- Wellesley Hospital may be covered under your plan.

Please be advised that no insurance company guarantees payment for speech-language therapy services. If the insurance company reviews the claim, it may be deemed a service or condition is not part of your insurance coverage, and you as the member may receive a bill. It is the patient's responsibility to understand his/her health plan requirements and we ask that you read this form to get a better understanding of what to look for in your insurance plan to understand if you may have financial responsibilities:

Please call your insurance company (the phone number is likely listed on the back of your card) to:

- Clarify your child's benefits for speech-language therapy services
- Determine if speech language services at Newton-Wellesley Hospital will be covered by your insurance plan.

  ☐ Yes ☐ No

It is recommended that you write down the following information when you contact your insurance company:

- Date/time of call: ______________________
- Name of insurance representative: ______________________
- Direct contact number/extension for representative: ______________________
- Confirmation code for the call: ______________________

The following are some questions to help clarify covered speech therapy services:

Will my insurance plan cover outpatient speech language therapy services at Newton Wellesley Hospital?

☐ Yes ☐ No

Is Newton Wellesley considered in-network for my plan (NPI number: 1992737761)?

☐ Yes ☐ No

What specific conditions/diagnoses will insurance cover? Is there a list of covered diagnosis codes?

____

What specific condition/diagnoses that are excluded? Is there a list of excluded diagnosis codes?

____

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Insurance Coverage for Speech and Language Therapy Services

The following is a list of common ICD-10 diagnosis codes and CPT codes used by speech language pathologists that may assist you in verifying insurance coverage. Consider giving the insurance representative both the ICD-10 code that matches your child's existing or suspected diagnosis and the CPT treatment or evaluation code that applies.

ICD-10 Diagnosis Codes

F80.0 Phonological Disorder

F80.1 Expressive Language Disorder

F80.2 Mixed Receptive-Expressive Language Disorder

F80.81 Childhood Onset Fluency Disorder (Stuttering)

R47.1 Dysarthria

R48.8 Other Symbolic Dysfunction (use with **F84.0** Autism as secondary diagnosis if applicable)

R48.8 Other Speech Disturbances

R48.2 Apraxia

R49.0 Dysphonia/Hoarseness (use with **J38.2** Nodules of Vocal Cords as secondary diagnosis if applicable)

M26.59 Other dentofacial functional abnormalities (use with

R47.89 Other Speech Disturbance if applicable)

CPT Treatment Codes

☐ **92507** Individual speech-language treatment

☐ **92508** Group speech-language treatment

CPT Evaluation Codes

☐ **92521** Evaluation of speech fluency (stuttering)

☐ **92522** Evaluation of speech sound production

☐ **92523** Evaluation of speech production AND receptive/expressive language

☐ **92523** Evaluation of voice and resonance

Does my plan require preauthorization, precertification, or a referral for speech language evaluation and therapy services?

☐ Yes ☐ No

How many visits does my insurance cover? ____ Is there a time limit to begin or to end?

☐ Yes ☐ No

Do I have a deductible or co-payment?

☐ Yes ☐ No