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 ❑ 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
Suite 1500, College Plaza
8215 – 112 Street
Edmonton, Alberta, Canada T6G 2C8

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, Suite 1500 College Plaza, 8215 – 112 Street, Edmonton, Alberta, T6G 2C8. Phone: (780) 492-2619. Email: **istar@ualberta.ca**