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

Intensive Aphasia Therapy Program Applicatio

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: ______________________________

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Allergies: ______________________________

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Other conditions:

☐ Diabetes	☐ Heart disease	☐ Seizures
☐ Depression	☐ Hypertension	☐ Syncope
☐ Chronic headaches	☐ Hemiparesis	☐ Visual eld de cits

Dietary restrictions: ______________________________

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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. ______________________________

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Additional information that might be pertinent to your patient's participation in our intensive comprehensive aphasia program. ______________________________

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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: ______________