ASU SPEECH AND HEARING CENTER
P.O. BOX 910 STATE UNIVERSITY, AR 72467-0910
PH. (870) 972-3301 FAX (870) 972-3788

B-5

DISPOSITION

Diagnostic clients being referred for services at ASU SHC, or current clients near semester end, should complete this form for scheduling in the subsequent semester. Forward the form to the Clinic Director.

Client's Name: ___________________________ Date:___________ File # (if returning) ____________
Client's Age: ________________Parent/Guardian:_____________________________________(if minor)

Type of Therapy: (Circle One)
Artic - Voice - Language - Literacy - Fluency - Head/Neck - Aural Rehab

PLEASE COMPLETE THE FOLLOWING TO ASSIST US IN SCHEDULING

Semester of Service (circle one) Spring Summer Fall YEAR_________

Check days you prefer to be scheduled for therapy.
____No preference
____Prefer to be scheduled on Monday and Wednesday
____Prefer to be scheduled on Tuesday and Thursday
____Prefer to be scheduled on Monday, Tuesday, Wednesday and Thursday

Note: Morning therapy times will be dependent upon availability of student clinicians and/or supervisors. Please indicate if interested in morning therapy and two (2) choices of days and times available.

1. ___________________________________ 2. ___________________________________

Indicate your 1st and 2nd choices of times to be scheduled for therapy.

Mon/Wed	Tues/Thursday	Mon. Thru Thurs.
____1:00-2:00	____1:00-2:00	____1:00-2:00
____2:00-3:00	____2:00-3:00	____2:00-3:00
____3:00-4:00	____3:00-4:00	____3:00-4:00
____4:00-5:00	____4:00-5:00	____4:00-5:00
____5:00-6:00*	____5:00-6:00*	____5:00-6:00*

* This time slot is not available for the Summer term.

Return this form to: CLINIC DIRECTOR

Revised: 1/28/14