MARY A. RACKHAM INSTITUTE
UNIVERSITY CENTER FOR
LANGUAGE AND LITERACY
UNIVERSITY OF MICHIGAN

University of Michigan Aphasia Program (UMAP)

Medical Information Form

The University of Michigan Aphasia Program (UMAP) offers intensive speech and language interventions for adults with various forms of aphasia and related speech and language difficulties.

Why Am I Getting This Form?

You are receiving this because you are treating someone who has requested to attend UMAP. They will have sent you this form directly or we may send it on their behalf. If there are additional permissions or releases you would like to secure, please call us at (734) 764-8440 or contact your patient directly.

About Our Program

Each client receives 19 hours of individual therapy and 5 hours of group communication therapy weekly during a session. The sessions typically run from 3-5 weeks. In addition, the program may be supplemented with daily homework and computer activities.
UMAP is the longest-running aphasia therapy program in the country and is one of few ICAPs—Intensive, Comprehensive Aphasia Programs—in the world.
To learn more, you can visit: mari.umich.edu/umap. We are happy to discuss our approach with you or answer any questions you may have.

What We Need From You

Although the program is administered in one building, clients must move from session to session, use an elevator, and be able to care independently for their own needs. In order to successfully participate in a UMAP session, we need to ensure that your patient is able to withstand the demands of such an intense schedule, with or without assistance.
Please complete this form to help us better understand the patient's needs and potential approach while they attend UMAP.

Patient Information

Patient Name:_____

Date of Birth:_____ Date of Onset: _____

Etiology of Communication Impairment: _____

Medication

Medication Name:_____

Dosage:_____ Frequency:_____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

If you have additional medications to add, please fill out the supplemental sheet provided at the end of the application.

Health Information

Allergies (food, pharmaceutical, substance, etc.): _____

_____

Please check all other conditions that apply.

- ☐ Hemiparesis
- ☐ Visual Field Deficits
- ☐ Hypertension
- ☐ Seizures
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Depression
- ☐ Syncope
- ☐ Chronic Headaches
- ☐ Anxiety
- ☐ Other: _____

Dietary Restrictions (low salt, etc.): _____

_____

Date of last completed physical exam: _____

Do you see this patient routinely?

- ☐ Yes
- ☐ No

Do you feel your patient would be physically capable of participating in an intensive speech-language program? (Approximately 5 hours of therapy per day.)

- ☐ Yes
- ☐ No

Please provide more details. If you answered no to the previous question, do you think they would be able to participate as a part-time client?

_____

_____

_____

Would your patient require any medical monitoring if involved in our program?

- ☐ Yes
- ☐ No

If yes, please describe: _____

Please mention anything else you think would be helpful for us to know when working with this client: _____

Before signing this document, verify that the content you are signing is correct.

X _____

Physician's signature

Physician's name (Please print): _____

Date_____ Physician's NPI#: _____

Address: _____

Phone number: _____

E-mail address: _____

Instructions for submission

Please send the form by fax or mail to the UCLL offices.

Fax: (734)647-2489 Attn. Dinah Young

Mail: Attn. Dinah Young
The University Center of Language and Literacy
1111 Catherine Street
Ann Arbor, MI 48104

Medication (Continued)

Medication Name:_____

Dosage:_____ Frequency:_____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____

Medication Name:_____

Dosage:_____ Frequency: _____

Reason: _____