How to Apply for a Constraint-Induced Aphasia Therapy (CIAT-II) Program

Constraint-Induced Aphasia Therapy (CI Therapy, or CIAT-II) Program
The CI therapy program offered in the Taub Therapy Clinic for speech/language problems after stroke, head injury, or tumor resection is called CIAT-II.

Who is a candidate for Constraint-Induced Aphasia Therapy (CI therapy, or CIAT-II)?
Most candidates for CIAT-II have already completed their traditional rehabilitation. However, many continue to suffer from the chronic effects of a stroke, traumatic brain injury, or other neurological injury. For appropriate candidates, CIAT-II has been found to be effective no matter how long ago the stroke or injury occurred. CIAT-II has specific requirements for acceptance into the program. Your application form and video are used by our therapists to see if you or your loved one meets criteria to receive treatment at this clinic.

What kind of time commitment is involved?
As the patient, you will play an integral role in your own success at the Taub Therapy Clinic. One of the reasons CI therapy is more effective than other therapy programs is because of its intensity. A typical CIAT-II session is four hours. Patients are seen for five days a week for three weeks. Patients must also complete tasks and/or exercises with the assistance of companion in the evenings and on weekends. After completing their CIAT-II program, patients are given an individualized program to follow at home. The patient is also asked to complete four self-evaluations to help the clinic track progress and to make recommendations for improving the home program.

How do I apply?
Candidates must submit a written application and video to the Taub Therapy Clinic. There are two ways to send your application to the Taub Therapy Clinic including:

1. Download and print the pdf version of the application form and return it with the required videos by email Taubclinic@uabmc.edu, fax (205)975-9700, or by mail (address below).

2. Request an application form by calling 1-866-554-TAUB (8282) and return it with the required videos by email Taubclinic@uabmc.edu, fax (205)975-9700, or by mail (address below).

Mailing Address:
Taub Therapy Clinic
Attn: CIAT-II
Spain Rehabilitation Center
Room R385
1717 6th Avenue South
Birmingham, AL 35249
PATIENT INFORMATION FORM

PATIENT INFORMATION
Name: ____________________________
Address: ____________________________
Phone: ( ) ________________________ Email: ____________________________
Gender: Male Female Date of Birth: ____________________ Age: __________
Last grade of school completed: ____________________________ Occupation: ____________________________

CAREGIVER INFORMATION*
*caregiver other than a physician (could include a family member, friend, nurse, etc.)
Name: ____________________________
Address: ____________________________
Phone: ( ) ________________________ Email: ____________________________
Relationship to Patient: ____________________________ Phone: ( ) ________________________
Additional Contact Person: ____________________________

TYPE OF INJURY
Date of Injury: ___________ Side of Body Most Affected: ____________________________
☐ Stroke Dominant Hand Prior to the event: ____________________________ Left _____ Right _____
☐ Traumatic Brain Injury I am currently receiving: ____________________________
☐ Other ____________________________ PT Yes _____ No _____
Date of Last CT/MRI: ________ / ______ / ________ OT Yes _____ No _____
Please include last MRI/CT report, if possible Speech Yes _____ No _____

PERSONAL INFORMATION
Are you able to walk? Yes No
Do you use a wheelchair? Yes No
If you are able to walk, do you use a walker/cane? Yes No
Do you dress yourself? Yes No
Do you have swallowing problems? Yes No
Did you receive inpatient rehab? Yes No
If yes, when and how long? ____________________________
If there was one situation you could communicate well in, what would it be? ____________________________
Do you smoke? Yes No
Do you drink alcohol? Yes No
If yes, how much? ____________________________
MEDICATION INFORMATION

Please list all of your current medications and their intents.

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HEALTH INFORMATION

Please mark if you have a history of any of the following conditions.

Heart Disease | Yes | No |
--- | --- | --- |
Hypertension | Yes | No |
Pulmonary Disease | Yes | No |
Thyroid Gland Disease | Yes | No |
Seizures | Yes | No |
Allergies, Asthma | Yes | No |
Anemia or Other Blood Problems | Yes | No |
Dementia | Yes | No |
Cancer | Yes | No |
Depression | Yes | No |
Diabetes | Yes | No |
Head Injury or Surgery | Yes | No |
Other | Yes | No |

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN.

________________________

PLEASE LIST THE NAME/CONTACT INFORMATION OF ANY PHYSICIAN AND/OR THERAPISTS YOU ARE SEEING.

________________________
VIDEO INSTRUCTIONS

Dear Interested Patient and Caregiver:

In addition to sending your Patient Information Form, we also ask that you send in a video recording of the patient speaking with a caregiver or someone else. The purpose of the video is to determine if the patient is an appropriate candidate for CIAT therapy.

Listed below are the items you should include in the video. Please position the camera directly in front of the patient. The caregiver can describe what is required in the different tasks. However, we need to see what the patient can do on their own during the tasks.

Patient Home Video (items to be included)

I. Please instruct the patient to complete the following. The caregiver may get the patient started by starting each task. After the first two responses, the patient should be attempting the task alone. For example, the caregiver may start the first section by saying “Count with me…1, 2 _”. The patient would then continue counting with no assistance from the caregiver.

   a. Verbally count from 1-20 (Caregiver can start patient out by saying “1,2__”)

   b. Verbally name days of the week (Caregiver can start patient out by saying “Sunday, Monday _______”)

   c. Verbally name months of the year (Caregiver can start patient out by saying “January, February___”)

   d. Sing Happy Birthday aloud (Caregiver can start by singing 4 words of the song “happy birthday to you_______”)

II. Section B will allow us to determine how well the patient understands what is being said. The caregiver may only state the questions and directions. The caregiver may repeat the question if needed. If the patient does not respond after the first repetition, proceed to the next item. Be careful not to give the answer with gestures or nonverbal behaviors.
III. Simple, personal yes/no questions: For this section, the caregiver will need to indicate the correct answer on the video. For example, once the patient answers the question the caregiver can reply “that is correct you do live in an apartment” or “that is incorrect, you live in a house”.

1. Do you live in an apartment?
2. Do you have 10 children?
3. Do you like pizza?
4. Do you live in ________? (fill in the city or state)
5. Are you wearing a watch?

b. Complex yes/ no questions: No need for the caregiver to give the correct answer.

1. Do you get coffee from a cow?
2. Do you cut the grass with a lawn mower?
3. Does two nickels equal ten cents?
4. Do cats bark?
5. Do dogs wag their tails?

c. Following 1-step commands: Caregiver please be mindful not to give any help by gesturing or pointing.

1. Close your eyes.
2. Open your mouth.
3. Touch your nose.
4. Shrug your shoulders.
5. Make a fist.
IV. **Repetitions:** Please instruct the patient to repeat the following words, phrases and sentences.

**a. Single Words**
1. Brown
2. Chair
3. Purple
4. Emphasize
5. Seventeen seventy six.

**b. Phrases**
1. You know how.
2. Down to Earth
3. Let’s go.
4. Call me.
5. How are you?

**c. Sentences, both simple and complex**
1. I got home from work.
2. You should not tell her.
3. It is near the table in the dining room.
4. They heard him speak last night.
5. I stopped at his front door and rang the bell.
V. **Naming and describing**: In this section, the caregiver picks out 5 objects around the home. Hold an object in view of the camera. Instruct the patient to name the objects. Allow the patient time to name and then describe the objects. If they are having difficulty, the caregiver may help by starting the first sound of the object.

a. The caregiver uses simple objects around home one at a time and patient names these objects aloud. (examples: cup, brush, knife, comb and plate)

b. Patient then attempts to describe the object he/she has just named. The caregiver may start the description by asking “What do you do with a cup?”

VI. **Picture Description**: Instruct the patient to describe what is going on in an action picture found in your home. The picture may include a scene or picture illustrating an event. The caregiver may include family pictures of vacations or events. The caregiver may help by directing the patient’s attention to specific parts of the picture.

Please mail your video to the following address:

Leslie Harper  
SRC 212  
1717 6th Avenue South  
Birmingham, Al 35249

Please send us a VHS videotape or a DVD. If you have the capability you may attach your video file and patient information form and return it via E-mail to: lhharper@uabmc.edu

If you have any questions please do not hesitate to call or email.  
Sincerely,

UAB Speech and Hearing Staff  
Phone: (205) 934-4467  
Fax: (205) 934-7421