



Halton-Peel Community
APHASIA PROGRAMS

Halton-Peel Community Aphasia Programs

Mailing Address: c/o Monarch House 1405 North Service Rd. E. Unit 103

Oakville, L6H 1A7 Tel: 905-875-8474 Fax: 905-849-0424

www.h-pcap.com

Email: info@h-pcap.com

Referral Form

Please complete all fields below and fax to: 905-849-0424

Aphasia Program Locations – For complete address and times please visit our website.

Burlington Groups:	Royal Canadian Legion:	Tuesday AM	<input type="checkbox"/>	**Wellness House: Thursday PM	<input type="checkbox"/>
Milton Group:	Royal Canadian Legion:	Wednesday PM	<input type="checkbox"/>		
Oakville Groups:	Regional Learning Centre:	Monday AM	<input type="checkbox"/>	Tuesday AM	<input type="checkbox"/>
Mississauga Groups:	Mind Forward:	Thursday AM	<input type="checkbox"/>	Thursday PM	<input type="checkbox"/>
Brampton Groups:	Bramalea Civic Centre:	Wednesday AM	<input type="checkbox"/>	Friday AM	<input type="checkbox"/>
	Nance Horwood Place:	Wednesday PM	<input type="checkbox"/>	Friday PM	<input type="checkbox"/>

*mandatory required fields

**new applicants must attend Wellness House ½ day program

Applicant Information		
*First name:	*Last name:	
*Date of birth: mm / dd / yyyy	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	
*Address:	*City:	*Postal code:
Closest major intersection:		
House <input type="checkbox"/> Apartment <input type="checkbox"/> Condo <input type="checkbox"/> Retirement home <input type="checkbox"/> Supported Living <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other <input type="checkbox"/>		
*Home phone:	Cell phone:	*Email:
Transportation: Self <input type="checkbox"/> Family <input type="checkbox"/> Public transit (bus, taxi) <input type="checkbox"/> Paratransit (accessible) <input type="checkbox"/> Other <input type="checkbox"/> _____		
Languages spoken/written: Primary Language: _____ Other languages: _____		
Best Contact Person: Applicant <input type="checkbox"/> (If yes, please skip section) Primary caregiver/Support Person <input type="checkbox"/>		
*Name:	*Relationship:	
*Home phone:	*Cell:	*Email:
Address:	City:	Postal Code:
Referral Source		
Hospital <input type="checkbox"/> Day Program <input type="checkbox"/> Private Practice <input type="checkbox"/> Self/family <input type="checkbox"/> Other <input type="checkbox"/> _____		
Referral Agency Name:	Contact Name:	
Title:	Phone:	
Fax:	Email:	

Medical Information	
Cause of aphasia: <input type="checkbox"/> Stroke <input type="checkbox"/> Primary Progressive Aphasia <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Tumour <input type="checkbox"/> Other:	
Date of onset (stroke/brain Injury/illness) mm / dd / yyyy	Site of lesion:
Previous strokes/related incidents: mm / dd / yyyy	
Comments:	
Is there paralysis or weakness? <input type="checkbox"/> None Partial: <input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> Total	
Assistive Devices: <input type="checkbox"/> Communication Device: <input type="checkbox"/> Cane / walker <input type="checkbox"/> Wheelchair: <input type="checkbox"/> electric <input type="checkbox"/> manual <input type="checkbox"/> scooter <input type="checkbox"/> Other, (please specify):	Mobility Assistance: <input type="checkbox"/> Independent (no assistance needed) <input type="checkbox"/> Supervision <input type="checkbox"/> Full Assistance
Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Reduced, specify:	Hearing aids: <input type="checkbox"/> Left <input type="checkbox"/> Right
Vision: Glasses: <input type="checkbox"/> everyday <input type="checkbox"/> reading only <input type="checkbox"/> Visual/perception difficulties, specify:	
Please indicate any other disabilities or medical conditions: <input type="checkbox"/> Swallowing <input type="checkbox"/> Seizures <input type="checkbox"/> Communicable disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Special diet <input type="checkbox"/> Cognitive <input type="checkbox"/> Unstable medical condition <input type="checkbox"/> Allergies <input type="checkbox"/> Memory <input type="checkbox"/> Mental Health <input type="checkbox"/> Diabetes <input type="checkbox"/> Other: _____ <input type="checkbox"/> Cancer <input type="checkbox"/> High blood pressure	
Comments:	

***Applicant must be independent with toileting & feeding OR bring someone to assist**

Family Physician Information	
Name:	Address:
Phone:	Fax:

Speech and Language Therapy	
Is applicant receiving speech/language therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Where:	
Start date: mm / dd / yyyy	End date: <input type="checkbox"/> Ongoing mm / dd / yyyy
Frequency:	
Other therapy: <input type="checkbox"/> Social Worker <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Other:	

Please include speech-language assessments and progress notes if available, as well as any other relevant clinical documentation that may assist in learning more about the applicant's needs and functional abilities

Description of Applicant's Communication		
Check all that apply: <input type="checkbox"/> Aphasia <input type="checkbox"/> Apraxia <input type="checkbox"/> Dysarthria <input type="checkbox"/> Other:		
Auditory Comprehension (getting the message in)		
<input type="checkbox"/> No support <input type="checkbox"/> Some support <input type="checkbox"/> Dependent on Support		
Difficulty understanding: <input type="checkbox"/> Simple ideas and questions <input type="checkbox"/> New, complex, or lengthy material <input type="checkbox"/> Conversation in a group setting	Improves with: <input type="checkbox"/> Written support <input type="checkbox"/> Repetition/clarification <input type="checkbox"/> Picture support <input type="checkbox"/> Extra time/pauses <input type="checkbox"/> Gestures <input type="checkbox"/> Other:	
Client will indicate if he/she has not understood: <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No		
Comments:		
Verbal Expression (getting the message out)		
<input type="checkbox"/> No support <input type="checkbox"/> Some support <input type="checkbox"/> Dependent on Support		
<input type="checkbox"/> Non- verbal <input type="checkbox"/> Single words <input type="checkbox"/> Short phrases <input type="checkbox"/> Full sentences: <input type="checkbox"/> Fluent <input type="checkbox"/> Non-fluent	Improves with client using: <input type="checkbox"/> Writing <input type="checkbox"/> Communication book <input type="checkbox"/> Gestures <input type="checkbox"/> AAC device <input type="checkbox"/> Drawings <input type="checkbox"/> Pointing to: <input type="checkbox"/> pictures <input type="checkbox"/> resources <input type="checkbox"/> written words <input type="checkbox"/> Other:	
Word finding difficulty: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
<input type="checkbox"/> Repeated word/phrase <input type="checkbox"/> Jargon or non-words <input type="checkbox"/> Word substitutions <input type="checkbox"/> Awareness of errors		
Yes/No Response: <input type="checkbox"/> Unreliable, specify: <input type="checkbox"/> Reliable, specify: More reliable with: <input type="checkbox"/> Pointing to written Y/N <input type="checkbox"/> Pointing to picture support <input type="checkbox"/> Gesture <input type="checkbox"/> Other		
Reading: <input type="checkbox"/> Non-functional <input type="checkbox"/> Single Words <input type="checkbox"/> Simple sentences <input type="checkbox"/> Paragraphs <input type="checkbox"/> No difficulty	Writing: <input type="checkbox"/> Non- functional <input type="checkbox"/> Single Words <input type="checkbox"/> Sentences <input type="checkbox"/> No Difficulty	Communication with family members/others: <input type="checkbox"/> Able <input type="checkbox"/> Limited <input type="checkbox"/> Unable
Comments:		

Background Information	
Education:	
Current employment:	Previous employment:
Interests/Hobbies:	
History of mental illness and/or on-going social work and/or psychological intervention:	
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Common law <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Living Conditions/Arrangements:	
<input type="checkbox"/> Live alone	<input type="checkbox"/> Live with spouse or other adults
<input type="checkbox"/> Live alone with dependent children	<input type="checkbox"/> Live with spouse or other adults and dependent children
<input type="checkbox"/> Live with parents/step-parents	<input type="checkbox"/> Other
Support system/family coping:	
Other relevant information:	

Halton-Peel Community Aphasia Program
Please indicate the reason(s) you/the applicant would like to become a member of the Halton-Peel Community Aphasia programs:
<input type="checkbox"/> Maintain communication skills <input type="checkbox"/> Try new things <input type="checkbox"/> Be part of the community <input type="checkbox"/> Improve/maintain reading & writing <input type="checkbox"/> Improve communication skills <input type="checkbox"/> Other: _____ <input type="checkbox"/> Socialize

Please fax this completed form to (905) 849-0424.

The applicant or designated contact person will be contacted to arrange a visit to the program.
Please note that we collect client/caregiver email addresses in order to
send necessary paperwork prior to the initial visit.

Thank you for contacting the Halton-Peel Community Aphasia Programs!