**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 \*\*Wellness House: Thursday PM 🞐

**Milton** Group: Royal Canadian Legion: Wednesday PM

**Oakville** Groups: Regional Learning Centre: Tuesday AM Friday AM

**Mississauga** Groups: Mind Forward: Thursday AM Thursday PM

 Alzheimer Society Peel: Wednesday AM

**Brampton** Groups: Bramalea Civic Centre: Wednesday AM Friday AM

 Nance Horwood Place: Wednesday PM Friday PM

\*mandatory required fields \*\*new applicants must attend Wellness House ½ day program

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| **Applicant Information** |

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| \*First name: | \*Last name: |
| \*Date of birth:  mm / dd / yyyy | Gender: Male 🞐 Female 🞐 Other 🞐 |
| \*Address: | \*City: | \*Postal code: |
| Closest major intersection:  |
| House 🞐 Apartment 🞐 Condo 🞐 Retirement home 🞐 Supported Living 🞐 Long Term Care 🞐 Other 🞐 |
| \*Home phone:  | Cell phone:  | \*Email: |
| Transportation: Self 🞐 Family 🞐 Public transit (bus, taxi) 🞐 Paratransit (accessible) 🞐 Other 🞐 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Languages spoken/written:** Primary Language: Other languages:  |

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| **Best Contact Person:** Applicant 🞐 (If yes, please skip section) Primary caregiver/Support Person 🞐 |
| \*Name:  | \*Relationship:  |
| \*Home phone: | \*Cell: | \*Email:  |
| Address:  | City:  | Postal Code: |

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| **Referral Source** Hospital 🞐 Day Program 🞐 Private Practice 🞐 Self/family 🞐 Other 🞐 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referral Agency Name: | Contact Name: |
| Title: | Phone: |
| Fax: | Email: |

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| **Medical Information**  |
| Cause of aphasia: 🞐 Stroke 🞐 Primary Progressive Aphasia 🞐 Traumatic Brain Injury 🞐 Tumour 🞐 Other: |
| Date of onset (stroke/brain Injury/illness) mm / dd / yyyy | Site of lesion: |
| Previous strokes/related incidents: mm / dd / yyyyComments:   |
| Is there paralysis or weakness? 🞐 None Partial: 🞐 Left side 🞐 Right side 🞐 Total |
| Assistive Devices: 🞐 Communication Device: 🞐 Cane / walker 🞐 Wheelchair: 🞐 electric 🞐 manual 🞐 scooter 🞐 Other, (please specify):  | Mobility Assistance: 🞐 Independent (no assistance needed)🞐 Supervision🞐 Full Assistance  |
| Hearing: 🞐 Normal 🞐 Reduced, specify: Hearing aids: 🞐 Left 🞐 Right |
| Vision: Glasses: 🞐 everyday 🞐 reading only 🞐 Visual/perception difficulties, specify: 0 |
| Please indicate any other disabilities or medical conditions:🞐 Swallowing 🞐 Seizures 🞐 Communicable disease 🞐 Heart disease🞐 Special diet 🞐 Cognitive 🞐 Unstable medical condition 🞐 Allergies 🞐 Memory 🞐 Mental Health 🞐 Diabetes 🞐 Other: \_\_\_\_\_\_\_\_\_\_🞐 Cancer 🞐 High blood pressure Comments:  |
| **\*Applicant must be independent with toileting & feeding OR bring someone to assist**  |
| **Family Physician Information** |
| Name:  | Address:  |
| Phone:  | Fax:  |
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| **Speech and Language Therapy** |
| Is applicant receiving speech/language therapy: 🞐 Yes 🞐 No Where:  |
| Start date:  mm / dd / yyyy | End date: 🞐 Ongoing mm / dd / yyyy |
| Frequency: |
| Other therapy: 🞐 Social Worker 🞐 Physiotherapy 🞐 Occupational Therapy 🞐 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** |

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

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| **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: 🞐 Married 🞐 Common law 🞐 Single 🞐 Divorced 🞐 Separated 🞐 Widowed  |
| Living Conditions/Arrangements: 🞐 Live alone 🞐 Live with spouse or other adults🞐 Live alone with dependent children 🞐 Live with spouse or other adults and dependent children 🞐 Live with parents/step-parents 🞐 Other |
| Support system/family coping:  |
| Other relevant information:  |

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| **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: 🞐 Maintain communication skills 🞐 Try new things 🞐 Be part of the community 🞐 Improve/maintain reading & writing 🞐 Improve communication skills 🞐 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞐 Socialize |

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| **Client consent obtained to share the information on this referral** 🞐 Yes 🞐 No |

**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!