**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

|  |
| --- |
| **Applicant Information** |

|  |  |  |  |
| --- | --- | --- | --- |
| \*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: | | | |

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

****

****

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

|  |  |
| --- | --- |
| **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 / yyyy  Comments: | |
| 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: |
|  | |
| **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** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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: | | | |
|  | | | |
| **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: | | | |

|  |  |
| --- | --- |
| **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: | |

|  |
| --- |
| **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 |

|  |
| --- |
| **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!