Halton-Peel Community
APHASIA PROGRAMS

Halton-Peel Community Aphasia Programs

Virtual Services Referral Form

Please complete all fields below and fax to: 365.601.1690

COVID-19 Program Update: Please note, our aphasia programs are being offered virtually until further notice. Please visit our website for updates: www.h-pcap.com

Please note that we collect client/caregiver email addresses to send necessary information and paperwork prior to the initial visit.

Which service delivery method are you interested in?

☐ Virtual Services (*email must be provided)
☐ In-person services

Applicant Information		
First name:	Last name:	
Date of birth		Gender:
Address:	City:	Postal code:
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 ☐	
Do you wish to receive wait-list status updates? Yes ☐ No ☐	
Referral Agency Name:	Contact Name:
Title:	Phone:
Fax:	Email:

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Applicant's name: _____

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:	Mobility Assistance:
☐ Communication Device: ☐ Cane / walker ☐ Wheelchair: ☐ electric ☐ manual ☐ scooter ☐ Other, (please specify):	☐ Independent (no assistance needed) ☐ Supervision ☐ Full Assistance
Hearing: ☐ Normal ☐ Reduced, specify: Hearing aids: ☐ Left ☐ Right	Vision: ☐ Normal ☐ Visual/perception difficulties, specify: Glasses: ☐ everyday ☐ reading only

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:

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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Applicant's name: _____

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:	Improves with:
☐ Simple ideas and questions	☐ Written support ☐ Repetition/clarification
☐ New, complex, or lengthy material	☐ Picture support ☐ Extra time/pauses
☐ Conversation in a group setting	☐ 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	Improves with client using:
☐ Single words	☐ Writing ☐ Communication book
☐ Short phrases	☐ Gestures ☐ AAC device
☐ Full sentences: ☐ Fluent ☐ Non-fluent	☐ 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:	Writing:	Communication with family members/others:
☐ Non-functional	☐ Non-functional	☐ Able
☐ Single Words	☐ Single Words	☐ Limited
☐ Simple sentences	☐ Sentences	☐ Unable
☐ Paragraphs	☐ No Difficulty	
☐ No difficulty		

Comments:

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Applicant's name: _____

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 alone with dependent children ☐ Live with parents/step-parents	☐ Live with spouse or other adults ☐ Live with spouse or other adults and dependent children ☐ 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 and improve communication skills	☐ Learn more about aphasia and supportive conversation strategies
☐ Be part of the community	☐ Improve / maintain reading & writing
☐ Build confidence in communicating	☐ Other:
☐ Meet others living with aphasia	

Client consent obtained to share the information on this referral	☐ Yes	☐ No

Please fax this completed form and any additional attachments to 365.601.1690

The applicant or designated contact person will be contacted to arrange a virtual Observation Session. Thank you for contacting the Halton-Peel Community Aphasia Programs!

Any questions?

Please contact Intake Coordinator at 905.875.8474

Email: info@h-pcap.com