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 ☐	**Wellness House: Thursday PM ☐
Milton Group:	Royal Canadian Legion:	Wednesday PM ☐	*Referral to Wellness House completed* ☐
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:		Gender:
*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:

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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)	Site of lesion:

Previous strokes/related incidents:

Comments:

Is there paralysis or weakness?
☐ None Partial: ☐ Left side ☐ Right side ☐ Total

Assistive Devices:	Mobility Assistance:
☐ Communication Device:	☐ Independent (no assistance needed)
☐ Cane / walker	☐ Supervision
☐ Wheelchair: ☐ electric ☐ manual ☐ scooter	☐ Full Assistance
☐ Other, (please specify):	

Hearing:
☐ Normal ☐ Reduced, specify: Hearing aids: ☐ Left ☐ Right

Vision:
Glasses: ☐ everyday ☐ reading only ☐ Visual/perception difficulties, specify:

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:	End date: ☐ Ongoing

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

	Improves with client using:
☐ Non- verbal	☐ Writing ☐ Communication book
☐ Single words	☐ Gestures ☐ AAC device
☐ Short phrases	☐ Drawings
☐ Full sentences: ☐ Fluent ☐ Non-fluent	☐ 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 communication skills ☐ Be part of the community ☐ Improve communication skills ☐ Socialize	☐ Try new things ☐ Improve/maintain reading & writing ☐ Other:

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!