Halton-Peel Community Aphasia Programs

Tel: 905.875.8474 Fax: 365.601.1690
Website: www.h-pcap.com Email: info@h-pcap.com

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 currently offered virtually. To see in-person aphasia program locations, please visit our website.

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 mm / dd / yyyy		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 ☐	
Do you wish to receive wait-list status updates? Yes ☐ No ☐	
Referral Agency Name:	Contact Name:
Title:	Phone:
Fax:	Email:

Holton-Peel Community APHASIA PROGRAMS

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

Hearing:	Vision:
☐ Normal	☐ Normal
☐ Reduced, specify:	☐ Visual/perception difficulties, specify:
Hearing aids: ☐ Left ☐ Right	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:

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: mm / dd / yyyy ☐ 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

Halton-Peel Community
APHASIA PROGRAMS

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:

Halton-Peel Community APHASIA PROGRAMS

Applicant's name: ___________________________

Patient Assessment: ASHA NOMS FCM (To be completed by Health Service Provider only. If available, not required)					
	Score (pre & post)		**Date**	**N/A**	**Comments** (optional)
1. Comprehension				☐	
2. Speech				☐	
3. Problem Solving				☐	
4. Reading				☐	
5. Memory				☐	
				☐	

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 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!