HNHB Regional Aphasia Programs Referral Form

Some **groups** are being **held virtually. Please contact your local Aphasia Program.**

Program: ☐ ARTC (Brantford-Brant, Haldimand, Norfolk) ☐ H-PCAP (Burlington) ☐ NAP (Niagara) ☐ SAM (Hamilton & area)
Preferred Method of Service: ☐ Virtual ☐ In-Person

Applicant Information		
Name of Applicant:	**Date of birth:** _____ /_____ /_____ DD MMM YYYY	
Residence: ☐ Home ☐ Retirement Home ☐ Other:		
Address (#, street, suite)**:**	**City:**	**Postal code:**
Home phone:	**Cell:**	**Work:**
Email address:		
Primary language:	**Other languages:**	
Transportation: ☐ Self ☐ Family/friend ☐ Public Transportation ☐ Other:		
Family Doctor:	**Phone:**	**Address:**

Support Person/Emergency Contact		
Name:	**Relationship to applicant:**	
Home phone:	**Cell:**	**Work:**
Address:	**Email:**	

Current HNHB Home and Community Support Services (HCSS) Involvement: ☐ Yes ☐ No	
HNHB HCSS services received: ☐ Nursing ☐ Personal Support Worker (PSW) ☐ Speech Therapy (SLP) ☐ Physiotherapy (PT) ☐ Occupational Therapy (OT) ☐ Dietitian ☐ Social Worker (SW) ☐ Other:	
HNHB HCSS Case Manager:	**Phone:**
Client has provided consent to contact HNHB HCSS: ☐ Yes ☐ No	

Referral Information	
Referral Source: ☐ Hospital ☐ HNHB HCSS ☐ Adult Day Program ☐ SLP Private Practice ☐ Self/family ☐ Other:	
Referral Agency Name:	
Contact Name:	**Relationship to Applicant:**
Phone:	**Email:**

Medical Information

Cause of aphasia: ☐ Stroke ☐ Traumatic Brain Injury ☐ Tumour ☐ Primary Progressive Aphasia (PPA) ☐ Other:

Comments:

Date of onset: _____ /_____ /_____ DD MMM YYYY	**Previous strokes/related incidents:**

Vision: Glasses: ☐ Distance ☐ Reading ☐ Visual-perceptual difficulties, specify:

Hearing: ☐ Normal ☐ Reduced, specify: Hearing aids: ☐ left ☐ right

Other relevant medical information:

☐ Swallowing problems ☐ Falls risk ☐ Cardiac disease ☐ Other:
☐ Seizures ☐ Diabetes ☐ High blood pressure
☐ Memory deficits ☐ Mental health ☐ Allergies, specify:

Comments:

Mobility Aids: ☐ Wheelchair ☐ Cane ☐ Walker ☐ Scooter ☐ Other:

Transfers (e.g. sit to stand): ☐ Independent ☐ Assistance, specify:

Toileting: ☐ Independent ☐ Assistance, specify:

Speech and Language Therapy

Is applicant receiving speech/language Therapy: ☐ No ☐ Yes **Where:**

Start date: _____ /_____ /_____ DD MMM YYYY	**End date**: _____ /_____/_____ ☐ Ongoing DD MMM YYYY

Frequency:

Other therapy: ☐ Social Worker ☐ Physiotherapy ☐ Occupational Therapy ☐ Other:

**** Please include** speech language pathology **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 & questions

☐ new, complex, or lengthy material

☐ Conversation in a group setting

Client will indicate if he/she has not understood:

☐ Yes ☐ Sometimes ☐ No

Improves with:

☐ Written support

☐ Picture support

☐ Gestures

☐ Repetition/clarification

☐ Extra time/pauses

☐ Other:

Comments:

Verbal Expression (getting the message OUT): ☐ No support ☐ Some support ☐ Dependent on support

☐ Non-verbal ☐ Short phrases

☐ Single words ☐ Full sentences

☐ Fluent ☐ Non- Fluent

Word finding difficulty:

☐ mild ☐ moderate ☐ severe

☐ Repeated word/phrase: _____

☐ Word substitutions

☐ Jargon or non-words

☐ Awareness of errors

Improves with client using:

☐ Writing ☐ Communication book

☐ Gestures ☐ AAC device:

☐ Drawings

☐ Pointing to: ☐ pictures ☐ written words ☐ resources

☐ Other:

Yes/No Response: ☐ Unreliable, specify: ☐ Reliable, specify:

More reliable with: ☐ Pointing to written Y/N ☐ Pointing to picture support ☐ Gesture ☐ Other:

Communication with family members: ☐ Able ☐ Limited ☐ Unable **Others:** ☐ Able ☐ Limited ☐ Unable

Reading: ☐ Non-functional ☐ Single Words ☐ Simple Sentences ☐ Paragraphs ☐ No Difficulty

Writing: ☐ Non-functional ☐ Single Words ☐ Sentences ☐ No Difficulty

Comments:

Background Information (optional)	
Current employment:	**Past employment:**
Education:	
Interests/hobbies:	
Support system/family coping:	
Other relevant information:	

Please indicate why the applicant would like to join the Aphasia Program (check all that apply):

- ☐ Engage in conversation
- ☐ Improve/maintain communication skills
- ☐ Improve/maintain reading & writing skills
- ☐ Learn new ways to communicate
- ☐ Build confidence
- ☐ Meet other people with aphasia
- ☐ Socialize
- ☐ Learn more about aphasia
- ☐ Other:

Referral completed by: _____

Relationship to applicant: _____

Tel: _____ **Date:** _____

HNHB Regional Aphasia Programs
www.aphasiaonwest.ca

Adult Recreation Therapy Centre
APHASIA PROGRAM
Brantford-Brant, Haldimand, Norfolk

Tel: 519-753-1882 ext. 104

Fax: 519-753-0034

www.artc.ca

Halton-Peel Community
APHASIA PROGRAMS

Halton-Peel Community
APHASIA PROGRAM
Burlington

Tel: 905-875-8474

Fax: 365-601-1690

www.h-pcap.com

Niagara
APHASIA PROGRAM

Tel: 905-984-2621
Toll free: 1-877-212-3922

Fax: 905-984-6409

www.hnhbhealthline.ca

S.A.M.
APHASIA PROGRAM Hamilton and Surrounding Area

Tel: 905-525-5632

Fax: 905-525-4149

www.goodshepherdcentres.ca