**HNHB LHIN APHASIA PROGRAMS**

# Referral Form

**Program**: ☐ ARTC (Brant, Haldimand, Norfolk) ☐ H-PCAP (Burlington) ☐ NAP (Niagara) ☐ SAM (Hamilton & area)

## 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 LHIN (CCAC) Involvement: ☐ Yes ☐ No

**HNHB LHIN services received:** ☐ Nursing ☐ Personal Support Worker (PSW) ☐ Speech Therapy (SLP) ☐ Physiotherapy (PT) ☐ Occupational Therapy (OT) ☐ Dietitian ☐ Social Worker (SW) ☐ Other:

| | |
|---|---|
| **HNHB LHIN Case Manager:** | **Phone:** |

**Client has provided consent to contact HNHB LHIN:** ☐ Yes ☐ No

## Referral Information

**Referral Source:** ☐ Hospital ☐ HNHB LHIN ☐ 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**: _____ /_____/_____ (dd MMM yyyy) ☐ Ongoing

**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:** _____

Please **FAX** completed referrals to the appropriate program:

| HNHB Aphasia Programs | | | |
|---|---|---|---|
| **Adult Recreation Therapy Centre (ARTC) Aphasia Program**<br>Brantford-Brant, Haldimand, Norfolk<br>Tel: 519-753-1882<br>Fax: 519-753-0034<br>www.artc.ca | **Halton-Peel Community Aphasia Program (H-PCAP)**<br>Burlington<br>Tel: 905-875-8474<br>Fax: 905-849-0424<br>www.h-pcap.com | **Niagara Aphasia Program (NAP)**<br>Niagara<br>Tel: 905-371-1569<br>Fax: 905-371-9354<br>www.niagararegion.ca | **SAM Aphasia Program (SAM)**<br>Hamilton and surrounding area<br>Tel: 905-525-5632<br>Fax: 905-525-4149<br>www.samprogram.ca |