

HNHB LHIN APHASIA PROGRAMS Referral Form

Program: <input type="checkbox"/> ARTC (Brant, Haldimand, Norfolk) <input type="checkbox"/> H-PCAP (Burlington) <input type="checkbox"/> NAP (Niagara) <input type="checkbox"/> SAM (Hamilton & area)
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Applicant Information		
Name of Applicant:	Date of birth: ___/___/___ dd MMM yyyy	
Residence: <input type="checkbox"/> Home <input type="checkbox"/> Retirement Home <input type="checkbox"/> Other:		
Address (#, street, suite):	City:	Postal code:
Home phone:	Cell:	Work:
Email address:		
Primary language:	Other languages:	
Transportation: <input type="checkbox"/> Self <input type="checkbox"/> Family/friend <input type="checkbox"/> Public Transportation <input type="checkbox"/> Other:		
Family Doctor:	Phone:	Address:

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

Current HNHB LHIN (CCAC) Involvement: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HNHB LHIN services received: <input type="checkbox"/> Nursing <input type="checkbox"/> Personal Support Worker (PSW) <input type="checkbox"/> Speech Therapy (SLP) <input type="checkbox"/> Physiotherapy (PT) <input type="checkbox"/> Occupational Therapy (OT) <input type="checkbox"/> Dietitian <input type="checkbox"/> Social Worker (SW) <input type="checkbox"/> Other:	
HNHB LHIN Case Manager:	Phone:
Client has provided consent to contact HNHB LHIN: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Referral Information	
Referral Source: <input type="checkbox"/> Hospital <input type="checkbox"/> HNHB LHIN <input type="checkbox"/> Adult Day Program <input type="checkbox"/> SLP Private Practice <input type="checkbox"/> Self/family <input type="checkbox"/> Other:	
Referral Agency Name:	
Contact Name:	Relationship to Applicant:
Phone:	Email:

Medical Information	
Cause of aphasia: <input type="checkbox"/> Stroke <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Tumour <input type="checkbox"/> Primary Progressive Aphasia (PPA) <input type="checkbox"/> Other:	
Comments: 	
Date of onset: ____/____/____ <small>dd MMM yyyy</small>	Previous strokes/related incidents:
Vision: Glasses: <input type="checkbox"/> Distance <input type="checkbox"/> Reading <input type="checkbox"/> Visual-perceptual difficulties, specify:	
Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Reduced, specify: Hearing aids: <input type="checkbox"/> left <input type="checkbox"/> right	
Other relevant medical information: <input type="checkbox"/> Swallowing problems <input type="checkbox"/> Falls risk <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Other: <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Memory deficits <input type="checkbox"/> Mental health <input type="checkbox"/> Allergies, specify:	
Comments: 	
Mobility Aids: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Scooter <input type="checkbox"/> Other:	
Transfers (e.g. sit to stand): <input type="checkbox"/> Independent <input type="checkbox"/> Assistance, specify:	
Toileting: <input type="checkbox"/> Independent <input type="checkbox"/> Assistance, specify:	

Speech and Language Therapy	
Is applicant receiving speech/language Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes Where:	
Start date: ____/____/____ <small>dd MMM yyyy</small>	End date: ____/____/____ <input type="checkbox"/> Ongoing <small>dd MMM yyyy</small>
Frequency:	
Other therapy: <input type="checkbox"/> Social Worker <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> 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: <input type="checkbox"/> Aphasia <input type="checkbox"/> Apraxia <input type="checkbox"/> Dysarthria <input type="checkbox"/> Other:	
Auditory Comprehension (getting the message IN): <input type="checkbox"/> No Support <input type="checkbox"/> Some Support <input type="checkbox"/> Dependent on Support	
Difficulty understanding: <input type="checkbox"/> Simple ideas & questions <input type="checkbox"/> new, complex, or lengthy material <input type="checkbox"/> Conversation in a group setting Client will indicate if he/she has not understood: <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No	Improves with: <input type="checkbox"/> Written support <input type="checkbox"/> Picture support <input type="checkbox"/> Gestures <input type="checkbox"/> Repetition/clarification <input type="checkbox"/> Extra time/pauses <input type="checkbox"/> Other:
Comments:	
Verbal Expression (getting the message OUT): <input type="checkbox"/> No support <input type="checkbox"/> Some support <input type="checkbox"/> Dependent on support	
<input type="checkbox"/> Non-verbal <input type="checkbox"/> Short phrases <input type="checkbox"/> Single words <input type="checkbox"/> Full sentences <input type="checkbox"/> Fluent <input type="checkbox"/> Non- Fluent Word finding difficulty: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> Repeated word/phrase: _____ <input type="checkbox"/> Word substitutions <input type="checkbox"/> Jargon or non-words <input type="checkbox"/> Awareness of errors	Improves with client using: <input type="checkbox"/> Writing <input type="checkbox"/> Communication book <input type="checkbox"/> Gestures <input type="checkbox"/> AAC device: <input type="checkbox"/> Drawings <input type="checkbox"/> Pointing to: <input type="checkbox"/> pictures <input type="checkbox"/> written words <input type="checkbox"/> resources <input type="checkbox"/> Other:
Yes/No Response: <input type="checkbox"/> Unreliable, specify: _____ <input type="checkbox"/> Reliable, specify: _____ More reliable with: <input type="checkbox"/> Pointing to written Y/N <input type="checkbox"/> Pointing to picture support <input type="checkbox"/> Gesture <input type="checkbox"/> Other: _____	
Communication with family members: <input type="checkbox"/> Able <input type="checkbox"/> Limited <input type="checkbox"/> Unable Others: <input type="checkbox"/> Able <input type="checkbox"/> Limited <input type="checkbox"/> Unable	
Reading: <input type="checkbox"/> Non-functional <input type="checkbox"/> Single Words <input type="checkbox"/> Simple Sentences <input type="checkbox"/> Paragraphs <input type="checkbox"/> No Difficulty	
Writing: <input type="checkbox"/> Non-functional <input type="checkbox"/> Single Words <input type="checkbox"/> Sentences <input type="checkbox"/> 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):

<input type="checkbox"/> Engage in conversation	<input type="checkbox"/> Meet other people with aphasia
<input type="checkbox"/> Improve/maintain communication skills	<input type="checkbox"/> Socialize
<input type="checkbox"/> Improve/maintain reading & writing skills	<input type="checkbox"/> Learn more about aphasia
<input type="checkbox"/> Learn new ways to communicate	<input type="checkbox"/> Other:
<input type="checkbox"/> Build confidence	

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