HNHB Regional Aphasia Programs Referral Form

At this time, **most groups** are being **held virtually.**

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

Applicant Information					
Name of Applicant:			Date of birt		// DDMMMYYYY
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:		Ad	dress:	

Support Person/Emergency Contact				
Name:		Relationship to applicant:		
Home phone:	Cell:		Wo	rk:
Address:		Email:		
Current HNHB Home and Community Support Services (HCSS) Involvement:				
HNHB HCSS services received: INursing IPersonal Support Worker (PSW) Speech Therapy (SLP) IPhysiotherapy (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: Self/family Other: Self/family Self/family				
Referral Agency Name:				
Contact Name:		Relationship to Ap	plicant:	
Phone:		Email:		

Medical Information					
Cause of aphasia: Stroke Traumatic Brain Injury Tumour Primary Progressive Aphasia (PPA)					
Other:					
Comments:					
Date of onset: / / Previous strokes/related incidents:					
DD MMM YYYY					
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:					
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:			
End date: / / 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 Comments:	Improves with: Written support Picture support Gestures Repetition/clarification Extra time/pauses Other:		
Verbal Expression (getting the message OUT):	No support 🗆 Some support 🗖 Dependent on support		
□ Non-verbal □ Short phrases	Improves with client using:		
□ Single words □ Full sentences	□ Writing □ Communication book		
🗌 Fluent 🗌 Non- Fluent	□ Gestures □ AAC device:		
Word finding difficulty: Mord finding difficulty: Moderate Severe Repeated word/phrase:	 Drawings Pointing to: pictures written words resources 		
Word substitutions	Other:		
 Jargon or non-words Awareness of errors 			
Yes/No Response: Unreliable, specify: More reliable with: Pointing to written Y/N Pointing to picture support Gesture			
Communication with family members: Able Able Limited Dunable Others: Able Limited Dunable			
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	Meet other people with aphasia		
	Improve/maintain communication skills	□ Socialize		
	Improve/maintain reading & writing skills	Learn more about aphasia		
	Learn new ways to communicate	Other:		
	Build confidence			
R	Referral completed by:			
R	Relationship to applicant:			

Tel: ______

Date:_____

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

HNHB Regional Aphasia Programs				
Adult Recreation Therapy Centre (ARTC)	Halton-Peel Community Aphasia	Niagara Aphasia Program (NAP)	SAM Aphasia Program (SAM)	
Aphasia Program Brantford-Brant, Haldimand, Norfolk Tel: 519-753-1882 ext.104 Fax: 519-753-0034 artc.ca	Programs (H-PCAP) Burlington Tel: 905-875-8474 Fax: 365-601-1690 <u>h-pcap.com</u>	Niagara Tel: 905-984-2621 Toll free: 1-877-212-3922 Fax: 905-984-6409 <u>hnhbhealthline.ca</u>	Hamilton and surrounding area Tel: 905-525-5632 Fax: 905-525-4149 goodshepherdcentres.ca	