

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 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:** _____

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	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:
Client will indicate if he/she has not understood: <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No	
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 Regional Aphasia Programs			
Adult Recreation Therapy Centre (ARTC) Aphasia Program Brantford-Brant, Haldimand, Norfolk Tel: 519-753-1882 ext.104 Fax: 519-753-0034 artc.ca	Halton-Peel Community Aphasia Programs (H-PCAP) Burlington Tel: 905-875-8474 Fax: 365-601-1690 h-pcap.com	Niagara Aphasia Program (NAP) Niagara Tel: 905-984-2621 Toll free: 1-877-212-3922 Fax: 905-984-6409 hnhbhealthline.ca	SAM Aphasia Program (SAM) Hamilton and surrounding area Tel: 905-525-5632 Fax: 905-525-4149 goodshepherdcentres.ca