

# 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:** \_\_\_\_\_





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: \_\_\_\_\_

**HNHB Regional Aphasia Programs**

[www.aphasiaonwest.ca](http://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](http://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](http://www.h-pcap.com)



Niagara  
APHASIA PROGRAM

Tel: 905-984-2621

Toll free: 1-877-212-3922

Fax: 905-984-6409

[www.hnhbhealthline.ca](http://www.hnhbhealthline.ca)



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

Tel: 905-525-5632

Fax: 905-525-4149

[www.goodshepherdcentres.ca](http://www.goodshepherdcentres.ca)