## **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:	//		
<b>Residence:</b> □ Home □ Retirement Home	e 🗆 O	ther:				
Address (#, street, suite):		City:		Postal code:		
Home phone:	Cell:	Worl		:		
Email address:						
Primary language:	Primary language:		Other languages:			
<b>Transportation:</b> □ Self □ Family/friend □ Public Transportation □ Other:						
Family Doctor:	Phone	:	Address	Address:		
Support Person/Emergency Contact						
Name:		Relationship to applicant:				
Home phone:	Cell:	Work:				
Address:	I	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: $\square$ Yes $\square$ No						
Referral Information						
Referral Source: ☐ Hospital ☐ HNHB HCSS ☐ Adult Day Program ☐ SLP Private Practice ☐ Self/family ☐ Other:						
Referral Agency Name:						
Contact Name:	ı	Relationship to Applicant:				
Phone:	I	Email:				

HNHB Regional Aphasia Programs – Referral Form Applicant's name:					
Medical Information					
Cause of aphasia: □ Stroke □ Traumatic Brain Injury □ Tumour □ Primary Progressive Aphasia (PPA) □ Other:					
Comments:					
Date of onset: / / Previous strokes/related incidents:					
Vision: Glasses: □ Distance □ Reading □ Visual-perceptual difficulties, specify:					
<b>Hearing:</b> □ Normal □ Reduced, specify: Hearing aids: □ left □ right					
Other relevant medical information:					
<ul> <li>□ Swallowing problems</li> <li>□ Falls risk</li> <li>□ Cardiac disease</li> <li>□ Other:</li> <li>□ Seizures</li> <li>□ Diabetes</li> <li>□ High blood pressure</li> <li>□ Memory deficits</li> <li>□ Mental health</li> <li>□ Allergies, specify:</li> </ul>					
Comments:					
Mobility Aids: □ Wheelchair □ Cane □ Walker □ Scooter □ Other:					
Transfers (e.g. sit to stand): □ Independent □ Assistance, specify:					
<b>Toileting</b> : □ Independent □ Assistance, specify:					
Speech and Language Therapy   Is applicant receiving speech/language Therapy:   No   Yes   Where:					
Start date:        //					
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. **					

HNHB Regional Aphasia Programs – Referral Form Ap	oplicant's name:			
Description of Applicant's Communication				
Check all that apply: $\square$ Aphasia $\square$ Apraxia $\square$ Dy	ysarthria 🗆 Other:			
	No Support □ Some Support □ Dependent on Support			
Difficulty understanding:	Improves with:			
☐ Simple ideas & questions	☐ Written support			
new, complex, or lengthy material	☐ Picture support			
□ Conversation in a group setting	☐ Gestures			
Client will indicate if he/she has not understood:	Repetition/clarification			
☐ Yes ☐ Sometimes ☐ No	☐ Extra time/pauses			
	□ Other:			
Comments:				
Verbal Expression (getting the message OUT): ☐ No s	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:	□ Drawings			
☐ mild ☐ moderate ☐ severe	☐ Pointing to: ☐ pictures ☐ written words			
	□ resources			
Repeated word/phrase:	□ Other:			
☐ Word substitutions	Other:			
☐ Jargon or non-words				
☐ Awareness of errors				
7.Walchess of chois				
Yes/No Response: ☐ Unreliable, specify: ☐ Reliable, specify:				
More reliable with: □ Pointing to written Y/N □ Pointi	ng to picture support □ Gesture □ Other:			
Communication with family members: ☐ Able ☐ Limited ☐ Unable Others: ☐ Able ☐ Limited ☐ Unable				
<b>Reading:</b> □ Non-functional □ Single Words □ Simple	ple Sentences 🗆 Paragraphs 🗆 No Difficulty			
Writing: □ Non-functional □ Single Words □ Sentences □ No Difficulty				
Comments:				

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Background Information (optional)					
Current emp	loyment:	Past employment:			
Education:					
Interests/hob	obies:				
Support system/family coping:					
Other releva	nt 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	e/maintain communication skills	□ Socialize			
□ Improve	e/maintain reading & writing skills	□ Learn more about aphasia			
□ Learn n	ew ways to communicate	□ Other:			
□ Build co	nfidence				
Referral completed by:					
Relationship to	o applicant:				
Tel:	Date:				

## **HNHB Regional Aphasia Programs**

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



Halton-Peel Community APHASIA PROGRAM Burlington

Tel: 905-875-8474

Fax: 365-601-1690

www.h-pcap.com



Niagara APHASIA PROGRAM

Tel: 905-984-2621 Toll free: 1-877-212-3922

Fax: 905-984-6409

www.hnhbhealthline.ca



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

Tel: 905-525-5632

Fax: 905-525-4149

www.goodshepherdcentres.ca