

Halton-Peel Community Aphasia Programs

Virtual Services Referral Form

Please complete all fields below and fax to: [365.601.1690](tel:365.601.1690)

Our aphasia programs are currently available both virtually and in person.

For the latest updates, please visit our website: www.h-pcap.com.

Please note that we collect client/caregiver email addresses to send necessary information and paperwork prior to the initial visit.

Which service delivery method are you interested in?

☐ Virtual Services (*email must be provided)

☐ In-person services

Applicant Information		
First name:	Last name:	
Date of birth	Gender:	
Address:	City:	Postal code:
House <input type="checkbox"/> Apartment <input type="checkbox"/> Condo <input type="checkbox"/> Retirement home <input type="checkbox"/> Supported Living <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other <input type="checkbox"/>		
Home phone:	Cell phone:	Email:
Transportation: Self <input type="checkbox"/> Family <input type="checkbox"/> Public transit (bus, taxi) <input type="checkbox"/> Paratransit (accessible) <input type="checkbox"/> Other <input type="checkbox"/>		
Languages spoken/written:		
Primary Language:		Other languages:
Best Contact Person: Applicant <input type="checkbox"/> (If yes, please skip section) Primary caregiver/Support Person <input type="checkbox"/>		
Name:	Relationship:	
Home phone:	Cell:	Email:
Address:	City:	Postal Code:

Referral Source	
Hospital <input type="checkbox"/> Day Program <input type="checkbox"/> Private Practice <input type="checkbox"/> Self/family <input type="checkbox"/> Other <input type="checkbox"/>	
Do you wish to receive wait-list status updates? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Referral Agency Name:	Contact Name:
Title:	Phone:
Fax:	Email:

Medical Information

Cause of aphasia:

☐ Stroke ☐ Primary Progressive Aphasia ☐ Traumatic Brain Injury ☐ Tumour ☐ Other:

Date of onset
(stroke/brain injury/illness) mm / dd / yyyy

Site of lesion:

Previous strokes/related incidents:

mm / dd / yyyy

Comments:

Is there paralysis or weakness?

☐ None Partial: ☐ Left side ☐ Right side ☐ Total

Assistive Devices:

☐ Communication Device:
☐ Cane / walker
☐ Wheelchair: ☐ electric ☐ manual ☐ scooter
☐ Other, (please specify):

Mobility Assistance:

☐ Independent (no assistance needed)
☐ Supervision
☐ Full Assistance

Hearing:

☐ Normal
☐ Reduced, specify:
Hearing aids: ☐ Left ☐ Right

Vision:

☐ Normal
☐ Visual/perception difficulties, specify:
Glasses: ☐ everyday ☐ reading only

Please indicate any other disabilities or medical conditions:

☐ Swallowing ☐ Seizures ☐ Communicable disease ☐ Heart disease
☐ Special diet ☐ Cognitive ☐ Unstable medical condition ☐ Allergies
☐ Memory ☐ Mental Health ☐ Diabetes ☐ Other:
☐ Cancer ☐ High blood pressure

Comments:

Speech and Language Therapy

Is applicant receiving speech/language therapy: ☐ Yes ☐ No Where:

Start date:
mm / dd / yyyy

End date: ☐ Ongoing
mm / dd / yyyy

Frequency:

Other therapy: ☐ Social Worker ☐ Physiotherapy ☐ Occupational Therapy ☐ Other:

Please include speech-language 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 and questions
- ☐ New, complex, or lengthy material
- ☐ Conversation in a group setting

Improves with:

- ☐ Written support ☐ Repetition/clarification
- ☐ Picture support ☐ Extra time/pauses
- ☐ Gestures ☐ Other:

Client will indicate if he/she has not understood: ☐ Yes ☐ Sometimes ☐ No

Comments:

Verbal Expression (getting the message out)

☐ No support ☐ Some support ☐ Dependent on Support

☐ Non-verbal

☐ Single words

☐ Short phrases

☐ Full sentences: ☐ Fluent ☐ Non-fluent

Improves with client using:

- ☐ Writing ☐ Communication book
- ☐ Gestures ☐ AAC device
- ☐ Drawings
- ☐ Pointing to: ☐ pictures ☐ resources
- ☐ written words
- ☐ Other:

Word finding difficulty: ☐ Mild ☐ Moderate ☐ Severe

☐ Repeated word/phrase ☐ Jargon or non-words

☐ Word substitutions ☐ Awareness of errors

Yes/No Response: ☐ Unreliable, specify:

☐ Reliable, specify:

More reliable with: ☐ Pointing to written Y/N

☐ Pointing to picture support

☐ Gesture

☐ Other

Reading:

- ☐ Non-functional
- ☐ Single Words
- ☐ Simple sentences
- ☐ Paragraphs
- ☐ No difficulty

Writing:

- ☐ Non-functional
- ☐ Single Words
- ☐ Sentences
- ☐ No Difficulty

Communication with family members/others:

- ☐ Able
- ☐ Limited
- ☐ Unable

Comments:

Applicant's name: _____

Background Information			
Education:			
Current employment:	Previous employment:		
Interests/Hobbies:			
History of mental illness and/or on- going social work and/or psychological intervention:			
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Common law <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Living Conditions/Arrangements: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Live alone <input type="checkbox"/> Live alone with dependent children <input type="checkbox"/> Live with parents/step-parents </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Live with spouse or other adults <input type="checkbox"/> Live with spouse or other adults and dependent children <input type="checkbox"/> Other </td> </tr> </table>		<input type="checkbox"/> Live alone <input type="checkbox"/> Live alone with dependent children <input type="checkbox"/> Live with parents/step-parents	<input type="checkbox"/> Live with spouse or other adults <input type="checkbox"/> Live with spouse or other adults and dependent children <input type="checkbox"/> Other
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Support system/family coping:			
Other relevant information:			
Halton-Peel Community Aphasia Program			
Please indicate the reason(s) you/the applicant would like to become a member of the Halton-Peel Community Aphasia programs: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Maintain and improve communication skills <input type="checkbox"/> Be part of the community <input type="checkbox"/> Build confidence in communicating <input type="checkbox"/> Meet others living with aphasia </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Learn more about aphasia and supportive conversation strategies <input type="checkbox"/> Improve / maintain reading & writing <input type="checkbox"/> Other: </td> </tr> </table>		<input type="checkbox"/> Maintain and improve communication skills <input type="checkbox"/> Be part of the community <input type="checkbox"/> Build confidence in communicating <input type="checkbox"/> Meet others living with aphasia	<input type="checkbox"/> Learn more about aphasia and supportive conversation strategies <input type="checkbox"/> Improve / maintain reading & writing <input type="checkbox"/> Other:
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Client consent obtained to share the information on this referral <input type="checkbox"/> Yes <input type="checkbox"/> No 			

Please fax this completed form and any additional attachments to [365.601.1690](tel:365.601.1690)
The applicant or designated contact person will be contacted to arrange an Observation Session. Thank you for contacting the Halton-Peel Community Aphasia Programs!

Any questions?

Please contact Intake Coordinator at 905.875.8474
 Clinical services are provided by Evergreen Communication Therapy Ltd.
 Email: info@evergreen-therapy.ca