



APHASIA CENTRE OF OTTAWA

REFERRAL FORM

153 Chapel Street (Main Level)

Ottawa, ON K1N 1H5

Tel. (613) 567-1119

Fax (613) 241-4170

NAME OF APPLICANT: _____
FIRST NAME FAMILY NAME

DATE OF BIRTH: ___/___/___ AGE: _____
DD MM YY

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

HOME PHONE NUMBER: (____)_____ WORK PHONE NUMBER: (____)_____

NAME OF CONTACT PERSON: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

HOME PHONE NUMBER: (____)_____ WORK PHONE NUMBER: (____)_____

REFERRING PERSON: _____ PHONE NUMBER: (____)_____

PROFESSIONAL AFFILIATION: SPEECH LANGUAGE PATHOLOGIST _____
SOCIAL WORKER _____
FAMILY PHYSICIAN _____
OTHER (Please specify) _____

HOSPITAL OR AGENCY: _____

DATE OF BRAIN INJURY CAUSING APHASIA: ___/___/___ DIAGNOSIS: _____
DD MM YY

HOSPITALS & AGENCIES ATTENDED LENGTH & FREQUENCY OF SLP THERAPY

DATE OF DISCHARGE FROM REFERRING HOSPITAL OR AGENCY: ___/___/___
DD MM YY

PLEASE COMMENT ON PROGRESS IN THERAPY: _____

PLEASE DESCRIBE ANY COMPLICATING FACTORS: _____

NAME OF FAMILY PHYSICIAN: _____ PHONE NUMBER: (____)_____

LEVEL OF AMBULATION: _____ LEVEL OF INDEPENDENCE: _____

(If an applicant cannot use the toilet independently, he or she must bring someone to assist.)

PLEASE CONTINUE ON REVERSE

PLEASE DESCRIBE APPLICANT'S PRESENT COMMUNICATION:

- severe receptive difficulties
- severe expressive difficulties
- understands words and uncomplicated phrases
- produces single words with a lot of cueing
- difficulty initiating verbal interaction
- understands conversation on 1:1 basis
- can say single words and some phrases
- good understanding
- can indicate basic wants and needs verbally
- moderate word-finding difficulty
- mild receptive and expressive difficulties

COMMENTS: _____

LANGUAGES SPOKEN: 1ST _____ 2ND _____ OTHER _____

PRAGMATICS: _____

DOES APPLICANT HAVE A COMMUNICATION BOOK? YES _____ NO _____

IF YES, HOW IS COMMUNICATION BOOK USED? _____

WHAT OTHER FACILITATORY STRATEGIES HAVE BEEN USEFUL? _____

VISION: _____ **HEARING:** _____ **PRE-MORBID HANDEDNESS:** _____

EDUCATION: _____ **PREVIOUS EMPLOYMENT:** _____

HAS APPLICANT LEFT EMPLOYMENT DUE TO BRAIN INJURY? YES _____ NO _____

APPLICANTS MAIN SOCIAL CONTACTS: _____

APPLICANTS INTERESTS AND HOBBIES: _____

After this referral has been received, the speech-language pathologist and social worker will arrange to have a home visit with the applicant and his or her family. The purpose of the home visit is to evaluate specific needs, to discuss present concerns, and to assess which programs offered by the Aphasia Centre of Ottawa may be of benefit. Following the home visit, the applicant and family may begin the program(s) as soon as there is an opening.

To enable us to maintain continuity and to provide the best service possible, please forward all recent assessments and progress reports. We especially value your description of the applicant's "functional communication" and how he or she interacts in conversation. Information on the family and extended support network is also appreciated.

I have explained this information to _____ and believe it was understood.
applicant's name

DATE: _____ **REFERRING PERSON'S SIGNATURE:** _____

I agree to this referral to the Aphasia Centre of Ottawa

DATE: _____ **APPLICANT'S SIGNATURE:** _____