Referral Form

Aphasia Centre of Ottawa
2081 Merivale Road, Suite 300, Ottawa, Ontario K2G 1G9
Tel. 613- 567-1119 Fax. 613-567-8930

NAME OF APPLICANT: _____
FIRST NAME FAMILY NAME

DATE OF BIRTH: ____/____/_____ **AGE:** _____ **GENDER:** _____
DD MM YYYY

ADDRESS: _____ **CITY:** _____ **POSTAL CODE:** _____

PRIMARY PHONE NUMBER: _____
Please Indicate: ☐ ***Home*** ☐ ***Work*** ☐ ***Cell***

ALTERNATE PHONE NUMBER(S): _____ _____
Please Indicate: ☐ ***Home*** ☐ ***Work*** ☐ ***Cell*** ☐ ***Home*** ☐ ***Work*** ☐ ***Cell***

E-mail ADDRESS: _____

NAME OF CONTACT PERSON: _____ **RELATIONSHIP:** _____

ADDRESS: _____ **CITY:** _____ **POSTAL CODE:** _____

PRIMARY PHONE NUMBER: _____
Please Indicate: ☐ ***Home*** ☐ ***Work*** ☐ ***Cell***

ALTERNATE PHONE NUMBER(S): _____ _____
Please Indicate: ☐ ***Home*** ☐ ***Work*** ☐ ***Cell*** ☐ ***Home*** ☐ ***Work*** ☐ ***Cell***

E-mail ADDRESS: _____

Upon referral, please contact: ☐ **Applicant** ☐ **Contact person**

REFERRING PERSON: _____ **PHONE NUMBER:** _____

E-mail ADDRESS: _____

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

HOSPITAL OR AGENCY: _____

DATE OF BRAIN INJURY CAUSING APHASIA: _____/_____/_____
DD MM YYYY

DIAGNOSIS: _____

MEDICAL REPORTS ATTACHED: ☐ Yes ☐ No

HOSPITALS & AGENCIES ATTENDED	**LENGTH & FREQUENCY OF SLP THERAPY**
_____	_____
_____	_____
_____	_____

DATE OF DISCHARGE FROM REFERRING HOSPITAL OR AGENCY: ____/____/_____
DD MM YYYY

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 THE 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** _____

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** ☐

APPLICANT'S MAIN SOCIAL CONTACTS: _____

After this referral has been received, the speech-language pathologist and social worker will arrange to have an initial virtual meeting with the applicant and his or her family. The purpose of the initial virtual meeting 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.

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 understand that <u>all services currently provided</u> by the Aphasia Centre of Ottawa are <u>online</u>**

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:** _____

Physician's signature is <u>not obligatory</u>, but helpful when filing for insurance coverage (if applicable):

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