Referral Form

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

**Please be advised: Incomplete information may affect our ability to provide service.*

NAME OF APPLICANT: _____
FIRST NAME FAMILY NAME

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

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

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

EMAIL ADDRESS: _____

ALTERNATE CONTACT: _____ **RELATIONSHIP:** _____

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

EMAIL ADDRESS: _____

Please note: The individual with aphasia will be contacted first. The alternate contact will be contacted if required.

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

If you would like to receive occasional updates and information from the Aphasia Centre of Ottawa created for referring agents and professionals, please include your **email 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: _____

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

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

NAME OF FAMILY PHYSICIAN: _____ **PHONE NUMBER:** _____

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** _____

WHAT, IF ANY, COMMUNICATION STRATEGIES/AIDS HAVE BEEN USEFUL? _____

_____

_____

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

EDUCATION: _____ **PREVIOUS EMPLOYMENT:** _____

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

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

Please be advised 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)

Referring physicians, please also provide prescription for speech therapy and social work if indicated.