APHASIA INSTITUTE

Life's a Conversation

APHASIA REFERRAL FORM

Thank you for your interest in the Aphasia Institute – Pat Arato Aphasia Centre.

Please find enclosed a referral form for entry into our programs. Also find attached an aphasia-friendly document to receive consent from the potential client to send their information to us as well as to the Central Local Health Integration Network (LHIN); information sent to the LHIN will provide the potential client access to any appropriate supports, services or programs through the LHIN. We cannot process the referral unless the LHIN consent is received and all sections of the referral form are completed.

The Aphasia Institute offers a range of different programs for those affected by aphasia. Clients usually first participate in the Introductory Program, which is a 12-week psycho-educational and support program for people with aphasia and their partners; it introduces the person with aphasia to our model and helps prepare them for our larger program, the Community Aphasia Program (CAP). CAP offers a range of recreational, leisure and educational programs which are communicatively accessible. Additionally, support groups are available for families. All programs (other than support groups) are run by volunteers and supervised by professional staff. Our Outreach Program is offered to clients who are not able to attend on-site programs and live in the Greater Toronto Area. We also provide services to individuals with Primary Progressive Aphasia (PPA) – please see separate PPA referral form for more details.

The following admission criteria are to ensure our programs are appropriate for an individual with aphasia:

Inclusion (Eligibility) Criteria

- *Stroke, other etiology, e.g., ABI, tumor – if other criteria are met*
- *Left-sided, focal lesion*
- *Aphasia*
- *PPA – see separate referral form for more information*
- *Dysarthria and apraxia together with aphasia. The dysarthria and apraxia need to be far less significant than the aphasia – in other words, the aphasia is the biggest communication challenge*
- *Incontinence is self-managed*
- *1-person assist with transfers*
- *Able to function in a social group*

Exclusion Criteria

- *Unmanageable aggressive behaviours, verbally or physically; wandering*
- *Major cognitive difficulties*
- *Dysarthria and apraxia in the absence of aphasia*
- *Neurodegenerative/deteriorating changes (e.g., Parkinson's Disease), excluding PPA*
- *Bowel incontinence; 1:1 care needs (total care)*
- *Health care needs that cannot be met through our programs*

If you have any questions about our referral process, our criteria for admission, our programs, or obtaining a Speech-Language Pathology report to accompany the referral, please feel free to contact me.

Sincerely,

Allison Tedesco, MSW, RSW
Manager of Client Services/Social Worker
416-226-3636 ext. 26
atedesco@aphasia.ca

Aphasia is an acquired communication disorder caused by an injury to the brain that affects a person's ability to use language to communicate. It is the most often the result of stroke or head injury.

Aphasia Institute
The Pat Arato
Aphasia Centre
73 Scarsdale Road
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www.aphasia.ca

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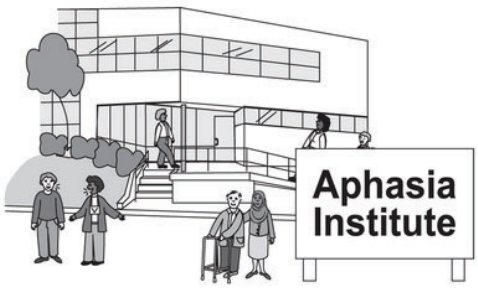
APHASIA INSTITUTE

Consent

Sharing Your **Personal** and **Health Information**



Home and Community Care

Agree?

YES ☐

NO ☐

Name _____

Signature _____

Witness _____

Date _____

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over **30 years** *of* touching lives
and rebuilding conversation

Referral Form

Please Note:
This referral cannot be processed without a Speech-Language Pathology assessment and progress reports

Date: (dd-mm-yyyy)		OHIP Number:	
Name of Applicant:			
Age:	D.O.B: (dd-mm-yyyy)	Gender:	☐ Female ☐ Male
Residence:	☐ Home ☐ Long Term Care ☐ Retirement Care		☐ _____
	☐ Other, specify:		☐ Prefer not to say
Address:		Apt:	City:
Postal Code:	Email:	☐ I give permission for this email address to be used to contact the applicant	
Closest major intersection:			
Telephone:	Home:	Cell:	
	Business: Ext.		
Transportation: ☐ Self ☐ Family/Friend ☐ Wheel-Trans (number:_____) ☐ Other:			
Family Doctor: Phone: Address:			

Best Contact Person	Applicant ☐ (If yes, skip this section)	Relationship, if other:	
Name:			
Address:		Apt:	City:
Postal Code:	Email:	☐ I give permission for this email address to be used to contact the Best Contact Person	
Telephone:	Home:	Cell:	

Referral Information

Referring SLP/Agent:	
Institution:	Phone:
Address:	City:
Postal Code:	Email:

Medical Information

Etiology:	☐ Stroke	☐ TBI	☐ Other, specify:	
If Stroke:	☐ Thrombosis	☐ Embolism	☐ Hemorrhage	☐ Aneurysm
Date of onset: (dd-mm-yyyy)	Number of incident(s):	Date(s):		
Site of lesion:	Premorbid Handedness: ☐ Left ☐ Right			
Institutions attended:				
Length of SLP Therapy: (dd-mm-yyyy) to (dd-mm-yyyy)	Frequency of therapy:			
Discharge date: (dd-mm-yyyy)				

Medical Information

Visual difficulties (Incident related and other):	
Hearing difficulties:	
☐ Hemiparesis	☐ Paralysis
Arms: ☐ Left ☐ Right	Arms: ☐ Left ☐ Right
Legs: ☐ Left ☐ Right	Legs: ☐ Left ☐ Right
Level of independence - toileting:	
Level of independence - mobility:	
Other relevant medical info: (e.g., HBP, diabetes, seizures, swallowing/choking, etc.)	

Background information

Languages spoken:
Education:
Current employment:
Previous employment:
Interests/hobbies:
Support system:
History of mental illness and/or on-going social work and/or psychology intervention:

Client Goals

Short Term:
Long Term:
Any barriers to goal achievement? Describe.
Any barriers to attending our program? Describe.

Note: The following sections must be completed.

Assessment of Communication Ability

Based On:	☐ Informal assessment/observation							
	☐ Formal test			Copy attached? ☐ Yes		☐ No		
Name of test:				Assessment Date: (dd-mm-yyyy)				
Aphasia Type:	Broca's	☐	Global	☐	Transcortical Motor	☐	Wernicke's	☐
	Anomic	☐	Conduction	☐	Transcortical Sensory	☐		

Comprehension

☐ Mild ☐ Mild -Mod ☐ Moderate ☐ Mod-Severe ☐ Severe

For simple, personally relevant conversations				For complex conversations			
☐ No support needed to get messages in				☐ No support needed to get messages in			
☐ Somewhat dependent on support to get messages in				☐ Somewhat dependent on support to get messages in			
☐ Dependent on support to get messages in				☐ Dependent on support to get messages in			
Types of Support Required:				Types of Support Required:			
☐ Key words	☐ Gesture	☐ Pictographic	☐ Resources	☐ Key words	☐ Gesture	☐ Pictographic	☐ Resources
☐ Low tech AAC	☐ High tech AAC	☐ Other		☐ Low tech AAC	☐ High tech AAC	☐ Other	

Comments:

Expression

☐ Mild ☐ Mild -Mod ☐ Moderate ☐ Mod-Severe ☐ Severe

	Types of Supported Required			
☐ No support needed to get messages out				
☐ Somewhat dependent on support to get message out	☐ Key words	☐ Gesture	☐ Pictographic	☐ Resources
☐ Dependent on support to get messages out	☐ Low tech AAC	☐ High tech AAC	☐ Other	

Speech		Word Finding	
☐ Non verbal	☐ Single words	☐ Mild	☐ Mild -Mod
☐ Short sentences/phrases	☐ Full sentences	☐ Moderate	☐ Mod-Severe
☐ Stereotypes:		☐ Severe	
☐ Paraphasias:			

Yes/No Response

☐ Unreliable	☐ Reliable	☐ Verbal	☐ Written	☐ Gesture	☐ Thumb	☐ Pointing to Y/N

Comments:

Motor Speech

☐ N/A ☐ Mild ☐ Mild-Mod ☐ Moderate ☐ Mod-Severe ☐ Severe

Comments:

Written Expression	☐ Mild	☐ Mild -Mod	☐ Moderate	☐ Mod-Severe	☐ Severe
☐ No functional writing		☐ Writes sentences			
☐ Writes names/some single words					
Types of Support Required:					
Comments:					

Reading Comprehension	☐ Mild	☐ Mild -Mod	☐ Moderate	☐ Mod-Severe	☐ Severe
☐ Understands single words			☐ Understands complex sentences		
☐ Understands simple sentences			☐ Understands paragraphs		
Types of Support Required:					
Comments:					

Pragmatic skills:
Partner - Facilitatory techniques found useful:
Client/Family expectations for future outcomes:
Other relevant information:

Please note all referrals are assumed to be for our Introductory Program/CAP. If you wish this applicant to be considered for Outreach, please check here ☐ and state rationale:

After this referral has been received, the applicant will be placed on our waiting list. They will be contacted by our intake staff within one month of receipt of referral. If the referral is deemed appropriate, the applicant will be invited in for a face-to-face meeting with a Speech-Language Pathologist and Social Worker. If the applicant meets all the criteria and wishes to proceed, they will be invited to our programs.

If you have any questions about our process or a potential applicant, please contact:

Allison Tedesco, MSW, RSW
Manager, Client Services / Social Worker
T: 416-226-3636 x 26
E: atedesco@aphasia.ca

☐ Yes, I have included a recent speech-language pathology assessment and progress reports
☐ No, I have not included a recent speech-language assessment and progress reports
Please state why reports have not been included:

_____

Signature of Speech-Language Pathologist Agent