



# Aphasia Institute Referral Form

## Community Aphasia Program (CAP)

Thank you for your interest in the Aphasia Institute. We offer a range of different programs for individuals who are living with Aphasia.

### Admission Process

Please complete and submit all intake forms to [aireferral@onelinkconnect.com](mailto:aireferral@onelinkconnect.com)  
(Or by Fax at 416-226-3706)

You will need to **complete** two intake forms:

- 1. Consent Form** – to send the potential client's information to Ontario Health atHome
- 2. The Aphasia Institute Referral Form (6 pages)**

## COMMUNITY APHASIA PROGRAMS

### Introductory Program: *New Beginnings*

New clients complete our Introductory Program (New Beginnings) as a first step. This program offers both clients with aphasia and their family members/partners education, psycho-social support, and conversation skill practice. After completing the New Beginnings program, our clients continue on to participate in the many types of group programs. Family members/partners may continue to meet in a support group setting.

### Group Programs *Onsite (at the Aphasia Institute) and Online (on Zoom)*

Our programs are delivered in group conversational settings. We offer a range of group programs that ensure participation in meaningful communication, recreation, leisure, and education opportunities. All our programs are communicatively accessible – designed so that people with aphasia can participate actively. Our conversation programs are run by highly trained volunteers and supervised by professional staff.

### Outreach Program *Individual conversation sessions*

For clients who are unable to attend our group programs, either in-person or online, our volunteers may engage in weekly telephone sessions. This programming is at the discretion of AI staff as resources are limited.

### Family Support Program

Regular Family Support Group meetings are available to all family members/significant others.

**Once we have processed the completed intake forms, we will schedule an assessment. The assessment will explore the potential client's ability to participate in our programs.**

Aphasia (UH-FAY-ZEE-UH) is a communication disorder, resulting from stroke, brain injury, or brain illness. Although people with aphasia remain competent, aphasia can affect speaking, understanding spoken language, reading, writing, and/or participation in daily conversations.

Aphasia Institute  
73 Scarsdale Road  
Toronto, ON M3B 2R2  
T 416.226.3636  
F 416.226.3706  
[www.aphasia.ca](http://www.aphasia.ca)



## Life's a Conversation

### Admission Criteria

We use the following criteria to determine if a potential client will be able to participate successfully in our group sessions.

**Inclusion Criteria** – to be eligible for an initial assessment

- Aphasia (usually from a left-sided, focal brain lesion)
- Cause: Stroke, other etiology, e.g., brain injury, tumor
- If a motor speech disorder is also present (e.g., dysarthria or apraxia), the aphasia must be the predominant communication disorder
- Able to function in a social group setting

**For Onsite Programs**

- Incontinence is self-managed
- 1-person assist with transfers

**Exclusion Criteria** – these factors would present barriers to participation in our group programs

- Unmanageable behaviours, e.g. verbal or physical aggression, wandering
- Significant cognitive difficulties, cognitive-communication disorder, or social-communication disorder

**Additional Factors – For Onsite Programs**

- 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, or our programs, please feel free to contact me.

Sincerely,

*Rumi Gutter*

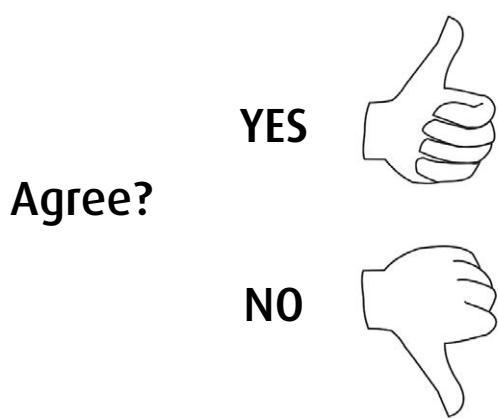
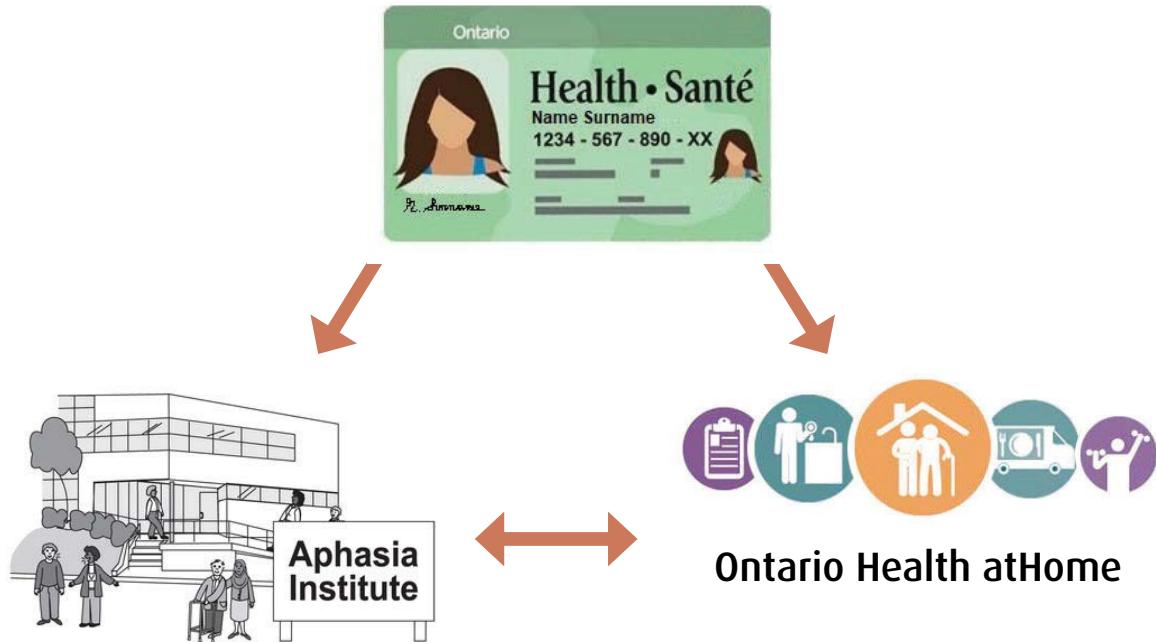
Rumi Gutter, MSW, RSW  
Manager of Client Services/Social Worker  
416-226-3636 ext. 146  
[rgutter@aphasia.ca](mailto:rgutter@aphasia.ca)

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# Consent

## Sharing Your Personal and Health Information



Name \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

If the patient cannot write, please fill in the check boxes, write their name, sign as a witness, and fill in the date.

For/On Behalf  
of Patient

**Note:** Speech-Language Pathology assessment reports and notes must accompany the intake forms.

Please indicate your preference for one or both of our programming locations:

Onsite (at the Aphasia Institute)

Online (on Zoom)

Both

<b>Client Details</b>		Date: (dd-mm-yyyy)	OHIP Number:
Name of Applicant:		<input type="checkbox"/> Female <input type="checkbox"/> Male	
Age:	Date of Birth: (dd-mm-yyyy)	<b>Gender:</b> _____  Residence: <input type="checkbox"/> Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Retirement Care Other, specify: _____	
Address:		Apt:	City:
Postal Code:	Email:		I give permission for this email address to be used
Closest Major Intersection:			
Home Phone:	Cell Phone:	Business Phone:	Ext.:
Transportation: <input type="checkbox"/> Self <input type="checkbox"/> Family/Friend <input type="checkbox"/> Wheel-Trans (number: _____) <input type="checkbox"/> Other:			
Family Doctor:		Phone:	Address:

<b>Emergency Contact Person</b>		Relationship	No Emergency Contact
Name:			
Address:		Apt.:	City:
Postal Code:	Email:		I give permission for this email address to be used
Home Phone:		Cell Phone:	

<b>Referral Information</b>			
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)					
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: "Description and Suggested Solutions":

Assessment of Communication Ability				
Based On:	Informal assessment/observation			
Formal test	Copy attached?	Yes	No	
Names of Tests:	Assessment Date: (dd-mm-yyyy)			
<b>Aphasia Type:</b>	<b>Nonfluent</b>		<b>Fluent</b>	
Sub-Type:	Broca's	Global	Wernicke's	Anomic
	Transcortical Motor	Mixed Transcortical	Transcortical Sensory	Conduction
Other:	Other: _____			

Comprehension	Mild	Mild-Mod	Moderate	Mod-Severe	Severe
<b>For simple, personally relevant conversations</b>	<b>For complex conversations</b>				
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				
<b>Types of Support Required:</b>	<b>Types of Support Required:</b>				
Key words	Gesture	Pictographic	Resources	Key words	Gesture
Low tech AAC	High tech AAC	Other:		Low tech AAC	High tech AAC
<b>Comments:</b>	<b>Comments:</b>				

Expression	Mild	Mild-Mod	Moderate	Mod-Severe	Severe				
No support needed to get messages out	<b>Types of Support Required</b>								
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:	
<b>Speech</b>	<b>Word Finding</b>								
Non verbal	Single words		Mild	Mild-Mod					
<input type="checkbox"/> Short sentences/phrases	Full sentences		Moderate	Mod-Severe					
Stereotypes:	Severe								
Paraphasias:									
<b>Yes/No Response</b>									
Accurate:	Verbal	Written	Gesture	Thumb	Facial Expression				
Comments:									

<b>Speech</b>					
Motor Speech:	Mild	Mild-Mod	Moderate	Mod-Severe	Severe
Apraxia:	Mild	Mild-Mod	Moderate	Mod-Severe	Severe
Dysarthria:	Mild	Mild-Mod	Moderate	Mod-Severe	Severe
Speech Intelligibility:	Completely	Mostly	Somewhat	Barely	Not at All
Comments:					

<b>Written Expression</b>					
Mild	Mild-Mod	Moderate	Mod-Severe	Severe	No functional writing
Writes	Uses a keyboard				
Writes/Types names/some single words	Writes/Types sentences				
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:

**Social Communication Difficulties (Pragmatics)**

No Difficulties Observed

Mild

Moderate

Severe

**Turn-Taking** (E.g., Interrupting, Monopolizing)

Comments:

**Appropriateness of Communication** (E.g., Angry responses, exclusive focus on own topics, vocabulary/topics suitability to the social situation)

Comments:

**Cognitive-Communication Difficulties**

No Difficulties Observed

Mild

Moderate

Severe

**Attention/Endurance** (E.g., Sustain attention throughout a group conversation session, shift attention as required among speakers and/or topics)

Comments:

**Memory** (E.g., Hold thoughts 'in mind', recall past experiences and information accurately)

Comments:

**Communication Partner** (if different from Emergency Contact)

If applicable, applicant's communication partner name:

Relationship:

"Is communication partner able to attend the "New Beginnings" program?    Yes    No (if no, please explain)

## Confirmation

Please note all referrals are assumed to be for our Introductory Group Program and Community Aphasia Programs.

I wish this applicant to be considered for Outreach (one-to-one sessions with a volunteer), please check here and explain the need.

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After this referral has been received, you and person being referred will receive confirmation of receipt of the referral.

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

Rumi Gutter, MSW, RSW, Manager, Client Services/ Social Worker

E-mail: [rgutter@aphasia.ca](mailto:rgutter@aphasia.ca) • Telephone: (416) 226-3636 x146

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:

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*Your Name (Speech – Language Pathologist / Agent)*

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*Your Signature*

By entering your full legal name here, you are representing this name as your signature.

