

**APHASIA INSTITUTE** The Pat Arato Aphasia Center

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**APHASIA**  
**INSTITUTE**

building communication ramps

## Referral Form

DATE:					
NAME OF APPLICANT:					
AGE:		DATE OF BIRTH:		SEX : <input type="checkbox"/> Female	
		dd/mm/yy		<input type="checkbox"/> Male	
				<input type="checkbox"/> Transgender	
ADDRESS:			APT:	CITY:	
POSTAL CODE:			EMAIL:		
HOME PHONE:			BUSINESS PHONE:		
MAJOR CROSS STREETS:					
<b>WHO IS THE BEST PERSON FOR OUR CENTRE TO CONTACT?</b>					
APPLICANT <input type="checkbox"/>		OTHER <input type="checkbox"/>		NAME:	
				RELATIONSHIP:	
ADDRESS (IF NOT THE SAME AS ABOVE):					
APT/STE:		CITY:		POSTAL CODE:	
HOME PHONE:			BUSINESS PHONE:		
EMAIL:					
<b>REFERRAL INFORMATION:</b>					
REFERRING SLP (OR AGENT):					
HOSPITAL/INSTITUTION:				PHONE:	
ADDRESS:			CITY:		POSTAL CODE:
EMAIL:					
<b>MEDICAL INFORMATION:</b>					
ETIOLOGY:	<input type="checkbox"/> STROKE	<input type="checkbox"/> ANEURSYM	<input type="checkbox"/> TBI	<input type="checkbox"/> PPA	<input type="checkbox"/> OTHER
DATE OF ONSET:			SITE OF LESION:		
HOSPITALS/INSTITUTIONS ATTENDED:					
LENGTH & FREQUENCY OF SLP THERAPY:					

DISCHARGE DATE: _____ dd/mm/yy	
VISUAL DIFFICULTIES (describe):	
HEARING DIFFICULTIES (describe):	
HISTORY OF MENTAL ILLNESS (describe):	
LEVEL OF INDEPENDENCE: (include toileting and mobility – <b>Applicant must be independent in the bathroom, or bring someone to assist</b> ):	
OTHER RELEVANT MEDICAL INFORMATION:	
<b>BACKGROUND INFORMATION:</b>	
LANGUAGES SPOKEN:	EDUCATION:
PREVIOUS EMPLOYMENT:	
INTERESTS/HOBBIES:	
SUPPORT SYSTEM:	
HAS CLIENT HAD ONGOING SOCIAL WORK AND/OR PSYCHOLOGY INTERVENTION (Please describe):	
<b>CLIENT GOALS:</b>	
SHORT TERM:	
LONG TERM:	
ANY BARRIERS TO GOAL ACHIEVEMENT? (describe):	
ANY BARRIERS TO ATTENDING OUR PROGRAM? (describe):	

**COMMUNICATION ABILITY:**

Aphasia Type (if known):

Aphasia Severity:

 mild moderate severe global**COMPREHENSION:**

- severe comprehension difficulty
- understands simple personally relevant conversation
- understands complex information
- has reliable yes/no response
- mild comprehension difficulty

Comments:

**VERBAL EXPRESSION:**

- non-verbal or no functional speech (i.e. verbal stereotype)
- can say some single words and/or phrases
- can indicate basic wants/needs verbally
- verbal apraxia or dysarthria
- moderate word finding difficulty
- mild word finding difficulty
- fluent aphasia

Comments:

**READING COMPREHENSION:**

- severely impaired
- understands single words
- understands sentences
- understands paragraphs
- mild reading impairment

Comments:

**WRITTEN EXPRESSION:**

- no functional writing
- writes name, some single words
- writes sentences
- mild writing impairment

Comments:

PRAGMATIC SKILLS:

FACILITATORY TECHNIQUES FOUND USEFUL:

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

After this referral has been received, the applicant will be placed on our waiting list. He/she will be contacted by our intake staff within two months of receipt of referral. The applicant will be offered an orientation session at which time programs/service will be discussed. If they wish to proceed with the program, he/she will be offered a time for an individual assessment with a Speech-Language Pathologist and Social Worker.

**Please note that this referral cannot be processed without accompanying recent speech-language assessment and progress reports.** In addition, please include any available information concerning **functional communication** to help provide the best programming for the applicant.

If you have questions about our process or a potential applicant, please contact, Charline Sherman, Social Worker at (416) 226-3636 x 15 or [csherman@aphasia.ca](mailto:csherman@aphasia.ca).

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SIGNATURE OF SPEECH-LANGUAGE PATHOLOGIST/REFERRAL AGENT