

HNHB Regional Aphasia Programs Referral Form

Some **groups** are being held virtually. Please contact your local Aphasia Program.

Program: ARTC (Brantford-Brant, Haldimand, Norfolk) H-PCAP (Burlington) NAP (Niagara) SAM (Hamilton & area)
Preferred Method of Service: Virtual In-Person

Applicant Information

Name of Applicant: _____ **Date of birth:** ____/____/____
DD MMM YYYY

Residence: Home Retirement Home Other:

Address (#, street, suite): _____ **City:** _____ **Postal code:** _____

Home phone: _____ **Cell:** _____ **Work:** _____

Email address: _____

Primary language: _____ **Other languages:** _____

Transportation: Self Family/friend Public Transportation Other:

Family Doctor: _____ **Phone:** _____ **Address:** _____

Support Person/Emergency Contact

Name: _____ **Relationship to applicant:** _____

Home phone: _____ **Cell:** _____ **Work:** _____

Address: _____ **Email:** _____

Current HNHB Home and Community Support Services (HCSS) Involvement: Yes No

HNHB HCSS services received: Nursing Personal Support Worker (PSW) Speech Therapy (SLP)
 Physiotherapy (PT) Occupational Therapy (OT) Dietitian Social Worker (SW) Other:

HNHB HCSS Case Manager: _____ **Phone:** _____

Client has provided consent to contact HNHB HCSS: Yes No

Referral Information

Referral Source: Hospital HNHB HCSS Adult Day Program SLP Private Practice
 Self/family Other:

Referral Agency Name: _____

Contact Name: _____ **Relationship to Applicant:** _____

Phone: _____ **Email:** _____

Background Information (optional)	
Current employment:	Past employment:
Education:	
Interests/hobbies:	
Support system/family coping:	
Other relevant information:	

Please indicate why the applicant would like to join the Aphasia Program (check all that apply):

<input type="checkbox"/> Engage in conversation	<input type="checkbox"/> Meet other people with aphasia
<input type="checkbox"/> Improve/maintain communication skills	<input type="checkbox"/> Socialize
<input type="checkbox"/> Improve/maintain reading & writing skills	<input type="checkbox"/> Learn more about aphasia
<input type="checkbox"/> Learn new ways to communicate	<input type="checkbox"/> Other:
<input type="checkbox"/> Build confidence	

Referral completed by: _____

Relationship to applicant: _____

Tel: _____ Date: _____

HNHB Regional Aphasia Programs

www.aphasiaonwest.ca



Adult Recreation
Therapy Centre
APHASIA PROGRAM
Brant, Haldimand, Norfolk

Tel: 519-753-1882 ext. 104

Fax: 519-753-0034

www.artc.ca



Halton-Peel Community
APHASIA PROGRAMS

Halton-Peel Community
APHASIA PROGRAM
Burlington

Tel: 905-875-8474

Fax: 365-601-1690

www.h-pcap.com



Niagara
APHASIA PROGRAM

Tel: 905-984-2621
Toll free: 1-877-212-3922

Fax: 905-984-6409

www.hnhbhealthline.ca



S.A.M.
APHASIA PROGRAM Hamilton and
Surrounding Area

Tel: 905-525-5632

Fax: 905-525-4149

www.goodshepherdcentres.ca