Referral/Application

Aphasia and Communication Disabilities
a Program of March of Dimes
13311 Yonge Street, Suite 202 Richmond Hill ON L4E 3L6
Toll 1-800-567-0315, (905)773-7758 Fax 1-844-990-4160
acdp@marchofdimes.ca
https://www.marchofdimes.ca/en-ca/programs/acs/acdp

Unless otherwise noted within a section, the information in this form is required so that we may assess the applicants entitlement to Aphasia and Communication Disabilities services. The information will be kept confidential, and will only be provided to persons who require the information in order to consider the application or in order to provide service to the applicant.

Applicant Information

The Aphasia and Communication Disabilities program runs Communication Programs at 6 sites, please check the applicant's preferred location in order of 1st, 2nd, 3rd	☐ Site to be determined - **Stouffville** ☐ Newmarket Health Centre 194 Eagle St. **Newmarket** ☐ Maple Health Centre 10424 Keele St. **Maple** ☐ 9401 Jane Street, **Vaughan** ☐ Westminster United Church 1850 Rossland Rd. **Whitby** ☐ Northminster United Church, 300 Sunset Blvd, **Peterborough**

☐ I am able to participate in virtual programming

TRANSPORTATION will be provided by ______________________________ (e.g. Mobility Transit, self, caregiver…)

Transportation arrangements should be discussed and made by **referral agent and client prior** to referral/application to the program.

How did you hear about our program: (colleagues, Doctor, SLP)______________________________

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**	***First Name:**	***Last Name:**	**Preferred Name:**

***Street Address (#, Street, Suite):**	***City/Town:**	***Postal Code:**
***Home Phone:** ( )	**E-mail Address:**	
Gender:	**Marital Status:** ☐Married ☐Common-law ☐ Single ☐ Separated ☐ Divorced ☐ Widowed	
***Birth Date** *(mm/dd/yy):*	**Health Card No.:**	
Language Preference: Written:	Spoken:	
Handedness: ☐Left ☐Right ☐Other:		

Primary Caregiver / Support Person

Name:		**Relationship:**	
Phone:	Home: ( )	Work: ( )	Cell: ( )
Address:		**Email:**	

Family Physician Information

Name:	**Address:**
Phone: ( )	**Fax:** ( )

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Referral Source Information ☐Hospital ☐CCAC ☐Physician ☐Self or Family ☐Other:	
Referral Source Agency Name:	
Contact Name:	**Contact Title:**
Address:	**Phone: ( )**
Fax: ( )	**Email:**
Disability / Medical History Information	
Date of Stroke or Brain Injury *(mm/dd/yy)*:	**Site of Lesion:**

Nature /Type of Injury /Event

☐ **Anoxia** ☐ Motor Vehicle Collision ☐ Tumor ☐Other:
☐ **Assault** ☐ Sports ☐ Viral Infection
☐ **Fall** ☐ Stroke ☐ Work-Related Injury

Circumstances surrounding injury:

Physical Changes *(e.g., right sided paresis/ paralysis/neglect, etc.)*:

Previous Medical / Rehabilitation Facilities

Facility Name	Length of Stay

Please list/indicate any other disabilities or medical conditions that may affect delivery of services:

☐ Swallowing ☐ Allergies ☐ Unstable Medical Condition ☐ Mental Health Issues
☐ Visual ☐ Special Diet ☐ Communicable Disease ☐ Other (explain)
☐ Hearing ☐ Heart Disease ☐ Cognitive

Other Information:

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Medical Information Prior to Acquired Brain Injury

Please list any illnesses, injuries or diagnosis prior to injury, and any related hospitalizations, treatments, etc. *(if additional space is required, please attach separate sheet)*:

Neuropsychological Assessments Completed: ☐ Yes ☐ No

Date Completed: *(mm/dd/yy)*	**By Whom:**

Address:	**Phone:** ( )

Seizures

Does applicant experience seizures: ☐ Yes ☐ No	**Date of last seizure:**

Describe:

Assistive Devices

Please indicate which, if any, of the following you use:

- ☐ Canes / Crutches / Walker
- ☐ Wheelchair (electric / manual)
- ☐ Scooter
- ☐ G-Tube Feeding
- ☐ Ventilator / breathing assist
- ☐ Braces
- ☐ Support Bars
- ☐ Raised Toilet Seat
- ☐ Communication Devices
- ☐ Technical Aids (ie. Palm pilot)
- ☐ Other, *please specify:* ______________________________

Description of Client's Communication

Speech Language Disability:

☐ **Aphasia:**	☐Mild	☐Moderate	☐Severe
☐ **Apraxia:**	☐Mild	☐Moderate	☐Severe
☐ **Dysarthria:**	☐Mild	☐Moderate	☐Severe
☐ **Cognitive Communication:**	☐Mild	☐Moderate	☐Severe
☐ **Other:**	☐Mild	☐Moderate	☐Severe

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Details:

Understanding of spoken words:

Speaking:

Reading:

Writing:

Memory:

Alternative or Augmentative/Communication Aids or Books:

Pragmatic Skills:

Useful Communication Strategies:

Other:

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MARCH OF DIMES CANADA / LA MARCHE DES DIX SOUS DU CANADA

Social Information

Living Conditions	Living Arrangements
☐ Home (Rented)	☐ Live alone
☐ Home (Owned)	☐ Live alone with dependent children
☐ Home (Family or Friend)	☐ Live with parents or step-parents
☐ Convalescent Hospital	☐ Live with spouse or other adults
☐ Long Term Care Setting	☐ Live with spouse or other adults and dependent children
☐ Hospital (Please name):	☐ Live in Shared Housing with support staff
☐ Institution	☐ Other: *(please explain)*
☐ Other: *(please explain)*	

Applicants who are now staying at hospital / rehabilitation unit:
Anticipated Discharge Date:

What will applicant's living situation be after he/she is discharged from hospital / rehab unit?

Decision Making

Substitute Decision Maker (SDM): Check what applies to your current situation:

☐ Applicant has Substitute Decision Maker:	Name:	Relationship to applicant:
☐ Power of Attorney-Personal care:	Name:	Relationship to applicant:

Note: please provide documentation if one of the above applies to you.

Has there been a capacity assessment: ☐Yes ☐No ***If Yes****, please provide a copy with this application.*

After this referral/application has been received, the applicant and his/her supporter will be contacted for an initial interview and a site visit if applicable.

Applicant is aware this referral/application has been submitted ☐Yes ☐No

Applicant consents that March of Dimes Canada can share health information with Home and Community Care Support Services (Ontario Health). ☐Yes ☐No

Caregiver is aware this referral/application has been submitted ☐Yes ☐No

For stroke survivors: I am interested in talking to an After Stroke Coordinator about local community and/or MODC stroke resources that may be helpful to me. ☐Yes ☐No

NOTE: Please include speech-language and other relevant rehabilitation assessments and progress reports. Information about the applicant's functional abilities, including communication, will help us provide the best programming. If referring an HCCSS client, please include a copy of the HCCSS assessments

Name/Title of Referring Agent *(print name)*:	**Signature:**	**Date** *(mm/dd/yy)*: