DALHOUSIE UNIVERSITY
School of Communication Sciences & Disorders

PPA Referral Form

Name _____

Date _____ Referred By _____

Primary Language _____ Other Language(s) _____

Main reason for referral:

- ☐ Word-finding problems
- ☐ Grammar/sentence formulation
- ☐ Understanding language
- ☐ Other: _____
- ☐ Speech sounds/fluency
- ☐ Reading/writing

Have you received a diagnosis of PPA or other diagnosis? ☐ Yes ☐ No

If other, what is the diagnosis? _____

When did changes begin? _____

Have symptoms worsened over time? ☐ Yes ☐ No

Other changes noticed:

☐ Memory ☐ Behaviour ☐ Movement ☐ None

Medical/neurological History (e.g. stroke, dementia, head injury, other)

_____

Seen by a neurologist? ☐ Yes ☐ No

Brain imaging done? ☐ Yes ☐ No

Impact on daily life:

_____

Communication Partner

Name: _____

Relationship to client: _____ Phone/email: _____

Observations/Concerns: _____

_____

Primary Contact for Follow-up

Name: _____

Phone: _____ Email: _____

Preferred contact method: ☐ Phone ☐ Email

Email completed form to speechclinics@dal.ca