MEDICAL INFORMATION FORM

To be completed by Physician

The **Inte**nsive **R**esidential **A**phasia **C**ommunication **T**herapy Program offers 4.5 weeks of intensive speech and language intervention for adults with communication difficulties secondary to brain injury. Each client receives four hours of individual therapy and computer therapy daily, as well as one hour of daily group therapy. In addition clients receive physiotherapy, individual therapeutic recreation as well as group therapeutic recreation activities. Off-site community integration activities are also scheduled. In order to facilitate communication carry-over, clients will be accompanied by a caregiver/partner who will participate in designated therapy and support group activities.

Patient Name: _____

Date of Birth: ____ ____ ____
M *D* *Y*

Date of last Physical Exam: ____ ____ ____
M *D* *Y*

Etiology of Communication Impairment: _____

Date of Onset: ____ ____ ____
M *D* *Y*

Basic Health Information:

Conditions: *(Please check)*

☐ Chronic Headaches	☐ Heart Disease	☐ Seizures
☐ Depression	☐ Hemiparesis	☐ Syncope
☐ Diabetes	☐ Hypertension	☐ Visual Field Deficit

Other Conditions: _____

Allergies: _____

Dietary Restrictions: _____

** *Please turn over…*

Do you see this patient routinely? ☐ **Yes** ☐ **No**

Do you feel your patient would be physically capable of participating in an intensive speech-language program? ☐ **Yes** ☐ **No**

Would you recommend that your patient participate in an intense speech-language program? ☐ **Yes** ☐ **No**

Would your patient require medical monitoring if involved in our program? ☐ **Yes** ☐ **No** **If yes, please describe:** _____

_____

Additional information that might be pertinent to working with this person on an intensive basis: _____

_____

Physician's Signature: _____

Physician's Name *(print)*: _____

Address: _____

Street

_____

City *Province/State* *Postal Code/Zip*

Phone & Email: _____

Date: _____

Thank You