NORTH MEMORIAL HEALTH

12000 Elm Creek Blvd # 210
Maple Grove, MN 55369
Phone: (763) 581-9100
Fax: (763) 581-9101

INTENSIVE APHASIA PROGRAM
Application

All information will be considered confidential

Date_____

APPLICANT INFORMATION			
Name			
Nickname			
Date of Birth	Age	SS# - -	Gender ☐M ☐F
Address			
City	State	Zip Code	
Home Phone ( )	Work/Alternate Phone ( )		
Cell Phone ( )	Email Address		
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner			
Do you need an interpreter? ☐ Yes ☐ No If yes, what kind?			
What is your ethnicity? ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Prefer not to say			
What is your race? ☐ White ☐ Black/African American ☐ Asian ☐ Native American/Alaska Native ☐ Native Hawaiian/Pacific ☐ Prefer not to say			
What is your religious preference?			
Date of Injury	Preferred dates of attendance		
PHYSICIAN INFORMATION			
Physician's Name	Clinic		
Address			
City	State	Zip Code	
Phone ( )	Fax ( )		
Neurologist's Name	Clinic		
Address			
City	State	Zip Code	
Phone ( )	Fax ( )		

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Emergency Contact/Next of Kin			
Emergency Contact:		Relationship to Patient:	
Home Phone ( )	Work/Alternate Phone ( )	Cell Phone ( )	
Street Address	City	State	Zip Code
Next of Kin:		Relationship to Patient:	
Home Phone ( )	Work/Alternate Phone ( )	Cell Phone ( )	
Street Address	City	State	Zip Code

INSURANCE INFORMATION		
Does your insurance policy require prior authorization? ☐ Yes ☐ No		
Primary Insurance:		
Member ID #:	Group #	Effective Date:
Subscriber Name (Name on card):		
Subscriber ID #:	Subscriber Date of Birth:	
Subscriber Social Security #: - -	Subscriber Employment Status:	
Subscriber Employer:	Subscriber Employer Phone Number:	
Subscriber Employment Address:		
City	State	Zip Code

Secondary Insurance:		
Member ID #:	Group #	Effective Date:
Subscriber Name (Name on card):		
Subscriber ID #:	Subscriber Date of Birth:	
Subscriber Social Security #: - -	Subscriber Employment Status:	
Subscriber Employer:	Subscriber Employer Phone Number:	
Subscriber Employment Address:		
City	State	Zip Code

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EDUCATIONAL HISTORY							
Check highest grade completed in school	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12
Did you attend a university? ☐ Yes ☐ No				Degree received:			
Is English your native language? ☐ Yes ☐ No							
How would you rate your English proficiency? ☐ Poor		☐ Fair		☐ Good/Native		☐ Superior	
Were you ever fluent in any other foreign language? ☐ Yes ☐ No If yes, what language?							

EMPLOYMENT HISTORY	
Current or Most Recent Occupation	Employer
Are you still employed? ☐ Yes ☐ No	
If no, are you on a leave of absence? ☐ Yes ☐ No	How long?

PERSONAL CARE	
Are you on any special diet? ☐ Yes ☐ No	If yes, please describe
Do you have any allergies? ☐ Yes ☐ No	If yes, what are they?
Do you regularly use a wheelchair? ☐ Yes ☐ No	If yes, are you independent in all transfers? ☐ Yes ☐ No
How far can you go independently (walking or wheelchair)? ☐ 25 yards or less ☐ 25 – 50 yards ☐ 50 – 100 yards ☐ 100 yards or more	
Are you able to follow a schedule without direct supervision? ☐ Yes ☐ No	Are you able to manage your time without direct supervision? ☐ Yes ☐ No

SPEECH/LANGUAGE EXAMINATION/THERAPY			
Agency 1:	Phone: ( )		
Street Address	City	State	Zip Code
Dates:			
Agency 2:	Phone: ( )		
Street Address	City	State	Zip Code
Dates:			

SPEECH AND LANGUAGE HISTORY
Did you have any speech or hearing problems before this illness/accident occurred? ☐ Yes ☐ No
If yes, describe:
Is there any history of speech, language or hearing problems in your family? ☐ Yes ☐ No

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COMMUNICATION SKILLS
What is your primary communication modality? (check one) ☐ Speaking ☐ Gestures ☐ Writing ☐ Drawing ☐ Communication Device
How do you speak, primarily? (check one) ☐ Single words ☐ Phrases ☐ Sentences ☐ Paragraphs
Can you formulate sentences and/or questions? ☐ Yes ☐ No
Can you understand yes/no questions? ☐ Yes ☐ No
Can you follow simple commands, (e.g. “go get the broom”) ☐ Yes ☐ No
Can you follow conversations? ☐ Yes ☐ No
Do you understand what you read? ☐ Yes ☐ No
Can you read the following: (check all that apply) ☐ Simple words ☐ Short sentences ☐ Newspapers ☐ Books
Can you ☐ write, ☐ print, and/or ☐ type your name? (check all that apply)
Can you fill out forms? ☐ Yes ☐ No
Do you write short messages, (e.g. “call your mom”)? ☐ Yes ☐ No
Do you use your non-preferred hand when writing and/or drawing? ☐ Yes ☐ No
What do you want to achieve from the Intensive Aphasia Program?
What is your goal?

ADDITIONAL INFORMATION
If you have seen a speech-language pathologist at any point during the last year, please ask your therapist to complete the enclosed **SLP Referral Form**.
All applicants, please have your doctor complete the enclosed **Medical Information Form.**

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INTENSIVE APHASIA PROGRAM
Medical Information Form

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Patient Name		
SS# - -	Date of Birth	Date of Injury

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Neurological conditions (please circle):

Brain tumor	Dementia	Syncope
Cognitive deficits (specify)	Head injury	Other:_____
CVA (specify)	Seizures	

Other conditions (please circle):

Chemical dependency	Heart disease	Mental illness
Chronic headaches	Hemiparesis	Visual field deficits (specify)
Diabetes	Hypertension	Other:_____

Dietary Restrictions:

Date of last completed physical/neurological exam:

How often do you see this patient?

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

Would your patient require any medical monitoring during therapy? ☐ Yes ☐ No

If yes, please describe:

MD Orders: I recommend that this patient receive evaluation and treatment for aphasia by Speech-Language Pathology at North Memorial Health.

Physician's Signature

Physician's Name (please print)

Street Address	City	State	Zip
Phone ( )	Date		
Fax ( )	Physician's UPIN #		

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INTENSIVE APHASIA PROGRAM
Speech-Language Pathologist Referral Form

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APPLICANT INFORMATION
Patient Name
Date of Birth

SPEECH-LANGUAGE PATHOLOGIST INFORMATION			
SLP Name:			
Phone: ( )	Fax: ( )		
Agency:	City	State	Zip Code
Dates:	Frequency of Therapy:		

Please fax completed SLP Referral Form along with patient speech records to North Memorial Health's Intensive Aphasia Program at (763) 581-9101.

Records may include any recent documentation, such as a progress report, daily note, or discharge summary.

Speech-Language Pathologist's Signature	Date

You are not required to provide any information beyond the records requested above. However, if there is any information you would like us to know regarding this applicant, please include it here. You are also welcome to contact us via phone at (763) 581-9100. Thank you.