Trinity College Dublin
The University of Dublin

connect
the communication disability network

The Dublin Conversation Partner Scheme

Name	
Date of Birth	
Address	
Telephone Number	
First Language	
Language(s) other than English	
SLT diagnosis:	
Date of onset:	
Clinic client attends:	

Next of Kin (and relationship)		
Address & Telephone Number (Next of Kin)		
Emergency Contact Number (if different from next of kin)		
Lives alone ☐	Lives with family ☐	Lives in residential care ☐

Does the client present with any of the following problems? Please indicate and provide brief details if relevant.	○ Cognitive difficulties ○ Visual / Hearing Impairment ○ Other conditions (e.g. diabetes, epilepsy) ○ Other:

Please answer the following questions to enable us to prioritise clients for the Conversation Partner Scheme and establish a waiting list.

Reasons for referring the client to the Conversation Partner Scheme	

Question	Yes	No
1. Does the client live alone/in residential care?	Yes ☐	No ☐
2. Is the client available on **Thursday** afternoons?	Yes ☐	No ☐
3. Has the client previously participated in the programme?	Yes ☐	No ☐
4. Has the client previously been on the waiting list for the programme?	Yes ☐	No ☐
5. Has the risk assessment form been completed (form and instructions attached)	Yes ☐	No ☐
6. Has the information booklet been reviewed with the client?	Yes ☐	No ☐

Rating **by the client** of the impact of aphasia on their life (see last page of information booklet for PWA)

Rating ☐

Name of Referrer:	
Email Address:	
Contact Number:	
Date of referral:	