St. Joseph's Healthcare Hamilton

Homes for Special Care Program

100 West 5th Street, P. O. Box 585
Hamilton, ON L8N 3K7 Canada
Phone 905 522-1155 Ext: 36328
Fax: 905 381-5600

REFERRAL FORMS AND INFORMATION PACKAGE

About the Program

The Homes for Special Care (HSC) Program offers more than just a place to live. It provides supportive housing with 24-hour supervision in a group home setting for individuals with serious mental health issues. Clinical staff from St. Joseph's Healthcare Centre for Mountain Health Services (CMHS) ensure that the residents' unique needs/choices (e.g. vocational) are assessed and addressed, and that their strengths or potential for learning are maximized. This is achieved in collaboration and partnership with residents, families, service-providers, home operators/staff, and others.

The HSC Program is directly accountable to both the Ministry of Health and Long-Term Care (MOHLTC) and St. Joseph's Healthcare CMHS. Homes within the HSC Program are independently owned and operated; however, they are inspected and licensed annually, on behalf of MOHLTC, by staff from the HSC Program office at CMHS. These homes are located in both rural and urban areas throughout the regions of Hamilton, Niagara, Brant, and Haldimand.

Additionally, this HSC Program (Central South) operates two Skills Centres that offer community-integrated therapeutic programs to assist HSC residents in regaining former skills or learning new ones. A range of prevocational, educational, recreational/social, and life skills programs are offered on-site at either the Hamilton or Niagara Skills Centre, or off-site at various locations throughout the residents' communities. Staff of the Centres, as well as our community partners, support participants in their skill acquisition and recovery efforts.

Referral Eligibility

- ✓ individual with a psychiatric diagnosis + current/prior psychiatric hospital admission(s)
- ✓ at least eighteen years of age, and voluntarily agreeing to enter HSC Program
- ✓ G.P. and psychiatrist designated for follow-up
- ✓ compliant with prescribed medication and follow-up
- ✓ not using/abusing alcohol, drugs or other substances
- ✓ not requiring the level of care associated with LTC facilities

Forms and Information Required

In order to process a referral for admission to the HSC Program, the following information and completed forms **must** be provided:

1. *HSC Program Referral Profile*
2. A **recent** psychosocial or other relevant assessment
3. Psychiatric History Record
4. Medication Record: include notation re **any allergies**
5. *Financial Responsibility Acknowledgement for Tenants of Homes for Special Care*
6. *Application for Reduction in HSC Rent and Care Fees*
7. Income verification, through (i) 'notice of assessment' (obtained by contacting Canada Revenue Agency at 1 – 800 – 959-8281 & asking for "option C report"), *OR* (ii) a copy of income tax return for the previous year, *OR* (iii) a copy of cheque stubs for ODSP, employment income, pension income, etc. which validate one month's income, *as well as* a copy of bank book and/or investment statements (verifying income earned on assets)
8. *Authorization for Disclosure of Personal Information,* indicating consent for HSC Program

Once the **completed** forms and information are received, and provided that the applicant meets the aforementioned eligibility criteria, a Referral Meeting *or* a combined Referral/Intake Meeting will be scheduled at the HSC Program office. Thereafter, admission to the Program will be discussed and decided at a subsequent HSC Clinical Team meeting.

Additional Requirements

1. The following results are also required, prior to the applicant's admission to the Program: **physical examination, TB skin test or chest X-Ray, and Hepatitis B test**. These may be faxed to the HSC Program office.
2. Scheduled visits by the prospective resident to his/her selected home, including dinner, overnight, and/or weekend visits. Note that visits to the homes cannot take place until the TB and Hep B test results are received.
3. Medication:
   - a list of medication as of the 1st day of admission to HSC (indicating any changes from initial referral package).
   - 2-week supply of medication to accompany the new resident to his/her new home.
   - prescription for sufficient medication until 1st medical or psychiatric follow up appointment.
   - a list of upcoming medical and/or psychiatric follow-up appointments.
4. A second *Authorization for Disclosure of Personal Information* indicating consent regarding the specific home operator and family physician, and other key service-providers.

Please note that an incomplete referral package cannot be processed or considered for admission. For questions or further information contact Lidia Fable: 905 522-1155 Ext. 36328 or the Program Manager, Dawnna Keith at Ext. 36641

HSC PROGRAM REFERRAL AND INTAKE CHECKLIST

CLIENT: _____

Required Files	Date Received	Comments
HSC Referral Profile		
Medication Record (**include allergies**)		
Psychiatric History Record		
Recent Psychosocial or other Assessment		
MOHLTC Application for Reduction in Home for Special Care Rent and Care Fees		
MOHLTC Financial Responsibility Acknowledgement		
Income Source ODSP,OW,Pension, OAS etc.		
Authorization for Disclosure of Personal Information (consent for examination by St. Joe's Healthcare CMHS Homes for Special Care)		
Physical Activity Consent Form.		
Copy of Notice of Assessment (Revenue Canada)		
Chest X-ray or TB Test - Date		
Hepatitis B Test - Date		
Other		

Ontario

Ministry of Health and Long-Term Care
Homes for Special Care
Ministère de la Santé et des Soins de longue durée
Foyers de soins spéciaux

Housing Program Referral Profile
Profil de renvoi au Programme de logement

Patient Information / Renseignements sur la patiente ou le patient

Date of Referral (yyyy/mm/dd) Date du renvoi (aaaa/mm/jj)	Date of Admission (yyyy/mm/dd) Date d'admission (aaaa/mm/jj)	Casebook Number Numéro du recueil de cas
Patient's Last Name Nom de famille de la patiente ou du patient	Patient's First Name & Initial Prénom et initiale de la patiente ou du patient	Date of Birth (yyyy/mm/dd) Date de naissance (aaaa/mm/jj)

Address Prior to Admission (include Street, City/Town, Province, Postal Code)
Adresse avant l'admission (rue, ville, province,

Birthplace Lieu de naissance	Religion Religion	Father's Name Nom du père	Mother's Maiden Name Nom de jeune fille de la mère
Marital Status/État matrimonial ☐ Single Célibataire ☐ Married Marié(e) ☐ Separated Séparé(e) ☐ Divorced Divorcé(e) ☐ Widowed Veuf(ve)		Sex ☐ Male Masculin ☐ Female Féminin	Language(s) Spoken Langue(s) parlée(s)
Social Insurance No. Numéro d'assurance sociale	Health Card No. Numéro de carte Santé	Drug Eligibility No. Numéro d'admissibilité au programme de médicaments	Public Guardian & Trustee No. Numéro du tuteur et curateur public

List Financial Resources
Énumérer les ressources financières

Has applicant ever been on any kind of financial aid program? *Please specify*
L'auteur de la demande a-t-il déjà été bénéficiaire de programmes d'aide financière? *Veuillez préciser.*

Who to contact in case of an emergency / Personne à qui s'adresser en cas d'urgence

Name Nom	Relationship Lien
Address Adresse	
Work Telephone Number (include area code) N° de téléphone au travail (y compris l'indicatif régional)	Home Telephone Number (include area code) N° de téléphone à la maison (y compris l'indicatif régional)

Substitution Decision Maker If/When Incapable
Personne qui prend les décisions au nom de la patients ou du patient, s'il y a lieu

☐ Same as above *or* / Comme ci-dessus *ou*

Name of Referring Agency/Hospital
Nom de l'organisme ou de l'hôpital qui a fait le renvoi

Address (include Street, City/Town, Province, Postal Code) Adresse (rue, ville, province, code postal)	Phone No. (Incl. Area Code) Téléphone (y compris l'ind. rég.)

Housing Program Referral Profile
Profil de renvoi au programme de logement

Patient's Last Name Nom de famille de la patiente ou du patient	Patient's First Name & Initial Prénom et initiale de la patiente ou du patient	Casebook Number Numéro du recueil de cas

Diagnostic Information / Renseignements diagnostiques

Psychiatric Diagnosis
Diagnostic psychiatrique

Secondary Diagnosis
Diagnostic secondaire

Highest School Grade Achieved Scolarité	Type of Program / Genre de formation ☐ Academic Générale ☐ Commercial Commercials ☐ Vocational Professionnelle

Brief outline of applicant's work history (*where, what, performance, etc.)*
Bref compte rendu des antécédents professionnels de l'auteur de la demande *(lieu, fonctions, rendement, etc.)*

Future rehabilitation goals and plans
Buts et plans en matière de réadaptation

Applicant's motivation for placement
Motivation de l'auteur de la demande quant au placement

Comments *Additional pertinent information that would warrant special attention):*
Observations *(renseignements supplémentaires qui demandent une attention spéciale)*

Referring Worker's Name Nom de la travailleuse ou du travailleur qui a fait le renvoi	Patient Care Unit *(if applicable)* Unité de soins du patient ou de la patiente *(s'il y a lieu)*	Telephone no. (Incl. Area code) Téléphone (y compris l'indicatif régional)

I have explained the Housing Program to the applicant and I feel that he/she is an appropriate candidate. It is understood that should the applicant be accepted in the Housing Program, I will be expected to continue to be involved in a consultative role.
J'ai expliqué le programme de logement à l'auteur de la demande et je crois qu'il est un candidat approprié. Il est entendu que si l'auteur de la demande est admis dans le programme de logement, je m'attends à continuer de jouer un rôle consultatif.

Signature Date (yyyy/mm/dd)(aaaa/mm/jj)

I have discussed the Housing Program with my worker and my physician. I understand and agree to abide by the rules and regulations of the program.
J'ai discuté du programme de logement avec ma travailleuse (mon travailleur) et mon médecin. Je comprends les règles et règlements du programme et j'accepte de les observer.

Signature Date (yyyy/mm/dd)(aaaa/mm/jj)

Patient Profile / Profil de la patiente ou du patient

Speech / Discors **Voice / Voix**	☐ Rational / Rationnel ☐ Quiet / Faible	☐ Clear / Clair ☐ Average / Moyenne	☐ Initiates / Iace des converstions ☐ Loud / Forte	☐ Responds / Répond ☐ Other *(specify)* Autre *(préciser)*

Comments:
Observations :

Housing Program Referral Profile
Profil de renvoi au programme de logement

Patient's Last Name Nom de famille de la patiente ou du patient	Patient's First Name & Initial Prénom et initiale de la patiente ou du patient	Casebook Number Numéro du recueil de cas

Patient Profile / Profil de la patiente ou du patient

Memory
Mémoire

Past Events Événements passée		☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle
Recent Events Événements récents		☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle
Orientation Orientation	Person	☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle
	Place	☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle
	Time	☐ Good Bonne	☐ Some Partielle	☐ Little or None Minime ou nulle

Anger
Colère

☐ Not a problem Pas un problème	☐ If provoked Si provoqué(e)	☐ Verbal Outbursts Emportements verbaux	☐ Aggressive behaviour Comportement agressif
☐ Frequent Fréquente	☐ Unpredictable Imprévisible	☐ Strikes Out Donne des coups	☐ Breaks/throws objects Brise/lance des objets

Comments:
Observations :

Activity Level
Activité

☐ Underactive
Peu Actif(ve)

☐ Average
Moyenne

☐ Quite Active
Très actif(ve)

☐ Restless
Agité(e)

Mood Disorders
Troubles de l'humeur

☐ Not Apparent
Non apparents

☐ Occasional Sadness
Tristesse occasionnelle

☐ Cries Frequently
Pleure souvent

☐ Has tried to hurt self
A tenté de se blesser

Comments:
Observations :

Bizarre Ideas
Idées bizarres

☐ Of Persecution Idés de persécution	☐ Of Importance Idées de grandeur	☐ Makes Up Events Fabule	☐ Stories From The Past Ressasse le passé
☐ Not Apparent Non apparentes	☐ Hallucinations Hallucinations	☐ Audio Auditives	☐ Visual Visuelles

Comments:
Observations :

Social Adjustments
Adaptions sociales

☐ Friendly Amical	☐ Reserved Réservé(e)	☐ Withdrawn Replié(e) sur soi	☐ Gregarious Grégaire
☐ Loner Solitaire	☐ Independent Indépendant(e)	☐ Attention Seeker Veut attirer l'attention	☐ Other Autre

Comments:
Observations :

Habits
Habitudes

☐ Smoking
Fume

☐ Pilfering
Commet des larcins

☐ Hoarding
Accumule

☐ Poor Budgeting Skills
A peine à gérer un budge

Comments
Observations :

Sexuality
Sexualité

☐ Masturbates
Se masturbe

☐ Exposes Self
S'exhibe

☐ Suggestive Touching
Fait des attouchements suggestifs

Comments
Observations :

Housing Program Referral Profile
Profil de renvoi au programme de logement

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Caution
Avertissement

- ☐ Elopement — Fait des fugues
- ☐ Sets Fires — Allume des incendies
- ☐ Careless Smoker — Fumer imprudent
- ☐ History of Medication Non-compliance — Ne prend pas toujours ses médicaments
- ☐ Substance Abuse — Toxicomane
- ☐ Alcohol — Consomme de l'alcohol
- ☐ Criminal Charges — Accusations criminelles
- ☐ Other — Autre

Comments:
Observations :

Mobility
Mobilité

- ☐ Walks Unaided — Marche sans aide

Comments:
Observtions :

Specific Recommendations or Comments:
Recommandations ou observations particuléres

Transfer Summary / Résumé du transfert

Briefly outline conditions limiting applicant's function:
Résumer les troubles qui limitent le fonctionnement de l'auteur de la demande :

MEDICATIONS / MÉDICAMENTS

Generic Name / Nom générique	Dosage / Posologie	Frequency / Fréquence	Route / Voie

☐ **Requires PRN Regularly / PRN souvent requir**

Generic Name / Nom générique	Dosage / Posologie	Frequency / Fréquence	Route / Voie

Diet
Régime alimentaire

- ☐ Regular — Ordinaire
- ☐ Other *(specify)* — Spécial *(veuillez ptréciser)*

Medical Problems *(i.e. incontinence)*
Problèmes médicaux *(c.-à-d. incontinence)*

- ☐ Acute — Aiguë
- ☐ Chronic — Chronique

Dates for Completed Investigations
Dates des investigations terminées

Chest X-ray Radiographie pulmonaire	Dental Examination Examen dentaire	Urinalysis Analyse d'urine	VDRL VDRL	Other Autre

In my opinion, this patient does not require further hospital care and any medical care required can be carried out by a community physician
A mon avis, cette patients ou ce patient n'as pas besoin de soins hospitaliers supplémentaires et les soins médicaux requis pourront être dispensés par un médecin de la collectivité.

Signature

Date (yyyy/mm/dd)(aaaa/mm/jj)

Housing Program Referral Profile
Profil de renvoi au programme de logement

Patient's Last Name Nom de famille de la patiente ou du patient	Patient's First Name & Initial Prénom et initiale de la patiente ou du patient	Casebook Number Numéro du recueil de cas

To be completed by the Housing Program / Réservé au programme de logement

The applicant was accepted
La demande a été acceptée
☐ Yes / Oui ☐ No / Non

If not accepted, specify reasons why
Si elle a été refusée, raisons

If accepted, address of Home
Si elle a été acceptée, adresse du foyer

Name of Worker Nom du travailleur ou de la travailleuse	Date of Placement Date du placement

Medication Record

Applicant's Name: _____ **Date:** _____

Current Medication	Dosage/ Frequency	Date Started	Date Reviewed	Reported/ Observed Side Effects

Allergies: No ___ Yes___ Specify _____

Psychiatric History Record

Applicant's Name: _____ **Date:** _____

Date of Last Psychiatric Assessment: _____

Psychiatric Assessment Completed by: _____

Signs and Symptoms of Decompensation: _____

_____

_____

Name of Facility	Admission Date	Discharge Date	Diagnosis	Residence on Discharge	Follow-up

***** Please complete and return with application package.*****

Ontario

Ministry of Health and Long-Term Care

Homes for Special Care

Application for Reduction in Home for Special Care Rent and Care Fees

A. Applicant

Last name	First name	Social Insurance no.

Name of the Home for Special Care	Address *(no. and street)*	City or town	Postal Code

B. Applicant Income Statement

☐ Notice of Assessment sent by the Minister of National Revenue, to the tenant, for the immediately preceding year is attached.

If the tenant is not required to file with the Canada Revenue Agency an income tax return for the immediately preceding year or if the Notice of Assessment is unavailable, attach (1) a statement describing circumstances and indicating what acceptable documentation is being used as proof of the tenant's disposable income for the immediately preceding year; and (2) proof of tenant's disposable income for that year.

Income	$ Monthly	$ Annually		$ Monthly	$ Annually
Ontario Disability Support Program (ODSP)			Old Age Security Pension		
Ontario Works			Other Pensions		
Employment Income			Employment Insurance		
Self-employment Income			Support Payments Received		
Interest Income			Other *(specify)*		
Canada Pension Plan Benefits					
			Total Income	$	$

1. *Net Income (Total Income – Expenses allowed by Revenue Canada) (line 236 from Notice of Assessment) $
2. Total Payable Federal and Provincial taxes (line 435 from Notice of Assessment) ..... $
3. Disposable Annual Income (subtract "item 2" from "item 1"). ..... $

* Income from Registered Disability Saving Plans is not to be included in Net Income.

C. Applicant Certification

I, the applicant, hereby apply for a reduction in rent and care fees, and declare that, to the best of my knowledge, the information I provided is true and complete. I consent to the Ministry of Health and Long-Term Care's collection and use and disclosure of the information provided on or attached to this form. I understand that this information will only be used or disclosed for the purpose of calculating and determining whether I am eligible for a reduction in rent and care fees. I understand that I may withhold my consent to the collection of this information, and if I do, I will not be eligible for a reduction in rent and care fees.

Signature of applicant	Date	Address	Telephone no.

Signature of witness	Date	Name of witness *(please print)*

Address of witness	City	Province	Postal Code

Signature of substitute decision maker	Date	Name of substitute decision maker

Address of substitute decision maker	City	Province	Postal Code

D. Calculated Rate *(to be completed by Home for Special Care Field Office Staff)*

Monthly Rate

(i) Monthly rate
(subtract the annual personal needs allowance total from Section B Disposable Annual Income item 3 and then ÷ 12) $

(ii) Lesser of line (i) above or the maximum prescribed rent and care rate *(monthly per diem)* ..... $

Daily Rate

Monthly rate above ÷ 30.4167 ..... $

Reviewed by *(Field Office staff)*	Date	Verified by *(Ministry staff)*	Date

This information is collected in order to calculate the reduction in the rent and care fee payable by the tenant of a Home for Special Care. The Authority for the collection is R.S.O. 1990, Regulation 638, s. 43 under the *Home for Special Care Act*. If you have questions about the collection of this information, please contact Manager of Supply and Financial Services Branch, 5700 Yonge Street, 10th floor, Toronto ON M2M 4K5. Tel no. (416) 327-7872.

Ontario

Ministry of Health
and Long-Term Care

Financial Responsibility Acknowledgement for Tenants of Homes for Special Care

In return for admission into a Home for Special Care as a tenant the applicant agrees and accepts to the following:

The applicant to a Home for Special Care or the applicant's lawful substitute decision maker agrees to provide information to the Ministry of Health and Long-Term Care relating to income as well as income on assets (bank accounts, investments) held by the applicant to a Home for Special Care or on this applicant's behalf. I understand that this information will only be used or disclosed for the purpose of calculating and determining whether I am eligible for a reduction in rent and care fees. I understand that I may withhold my consent to the collection of this information, and if I do, I will not be eligible for a reduction in rent and care fees.

The applicant further consents to the Ministry of Community and Social Services disclosing to the Ministry of Health and Long-Term Care's Homes for Special Care Program personal information about the applicant for the purpose of verifying the initial or ongoing eligibility for social assistance of the applicant who is the subject of this application for admission to a Home for Special Care.

A tenant of a Home for Special Care who is eighteen (18) years of age or older and who has income or a tenant's lawful substitute decision maker, is liable for payments made by the Ministry of Health and Long-Term Care on his or her behalf.

Where a tenant in a Home for Special Care has insufficient income to pay for his or her rent and care, the Minister of Health and Long-Term Care may pay to a licensee of a Homes for Special Care an amount for rent and care in accordance with Part IX of Regulation 636 of the *Homes for Special Care Act.*

In addition to the said rent and care payment the Minister may pay for any medical care, clothing, toiletries or other personal necessities required by and supplied to a tenant of a Home for Special Care. The Ministry of Health and Long-Term Care reserves the right to determine the amounts of these payments, the personal items, and manner of such payments.

The tenant or the tenant's lawful substitute decision maker agrees to pay costs incurred for rent and care, based on the tenant's income and in accordance with the said policies of the ministry. The tenant or the tenant's lawful substitute decision marker agrees to immediately report changes in income or $50.00 / month or more and to provide verification of the new income. The Minister may exercise all rights of recovery as set out in Part IX of Regulation 636 of the *Homes for Special Care Act.*

Liability and Indemnification

The Crown in right of Ontario will not be liable for any claim, damages or otherwise to the tenant or a tenant's lawful substitute decision maker arising from or connected with this financial responsibility acknowledgement form.

The tenant and/or a tenant's lawful substitute decision maker, will during and following this acknowledgement form, indemnify and save harmless the Crown in right of Ontario from and against all costs, losses, damages, judgements, claims, demands, suits, actions, complaints or other proceedings in any manner based upon, occasioned by or attributable to anything done or omitted to be done by the tenant, the tenant's spouse or the tenant's lawful substitute decision maker in connection with services provided by a Home for Special Care, purported to be provided or required to be provided by the Home for Special Care.

Term

This acknowledgement form will be in force while the tenant is a tenant in a Home for Special Care. The ministry reserves the right to pursue recoveries from the tenant or the tenant's lawful substitute decision maker while the tenant is a tenant in a Home for Special Care and after a tenant is discharged from a Home for Special Care.

Freedom of Information

Any information collected by the Ministry of Health and Long-Term Care under this financial responsibility acknowledgement form is subject to the provisions of the *Freedom of Information and Protection of Personal Privacy Act* R.S.O. 1990, C.F. 31.

Collection of the information on this form is necessary for the proper administration of authorized activity payment and recovery of recoverable amounts under the *Homes for Special Care Act.* For information about the payment and collection process contact the Manager of Supply and Financial Services Branch, 5700 Yonge Street, 10th Floor, Toronto ON M2M 4K5, Telephone 416 327-7972.

In Witness Whereof this acknowledgement form has been signed by the applicant or the applicant's lawful substitute decision maker.

Applicant

Name of applicant	Signature of applicant		Date
Home address	City / Town	Province	Postal Code

Lawful Substitute Decision Maker

Name of lawful substitute decision maker	Signature of lawful substitute decision maker		Date
Home address	City / Town	Province	Postal Code

Witness

Name of witness	Signature of witness		Date
Home address	City / Town	Province	Postal Code

St. Joseph's Healthcare Hamilton

- ☐ St. Joseph's Hospital
- ☐ Centre for Ambulatory Health Services
- ☐ Centre for Mountain Health Services
- ☐ Off-site Program _____

Authorization for Disclosure of Personal Information

Patient Identification

Patient's Name: _____ Date of Birth _____
DD/MM/YYYY

Address: _____

I the undersigned authorize: **CMHS HSC Program &**
Print name of Health Information Custodian/Facility

Disclose Personal Health Information to:

CMHS HSC Program &
Print Name and address of person /facility requesting the Information

Address City Postal Code

PURPOSE OF DISCLOSURE: x HEALTHCARE ☐ LEGAL PROCEEDING ☐ INSURANCE OTHER _____

The Personal Health Information I authorize to be disclosed:

- ☐ *X Discharge Summary:*

_____

- ☐ *X Information Relating to: ongoing care and my current status*

_____

- ☐ *X Other: any documentation/reports*

_____

*** IF THE PERSON SIGNING IS NOT THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO DO SO**

_____
Signature Print Name Relationship

_____
Witness Signature Print Name Date

THIS AUTHORIZATION MAY BE RESCINDED OR AMENDED IN WRITING AT ANY TIME PRIOR TO THE EXPIRATION DATE (3 MONTHS) EXCEPT WHERE ACTION HAS BEEN TAKEN IN RELIANCE OF THIS AUTHORIZATION

1. This authorization must contain the original signature of the patient or substitute decision maker or the legal representative if the patient is deceased, and the witness to the signature.
2. Requests for release of information must be dated after treatment dates.
3. Expiration Date: 3 months or as stated – 1 year

St. Joseph's Healthcare
Hamilton

- ☐ St. Joseph's Hospital
- ☐ Centre for Ambulatory Health Services
- ☐ Centre for Mountain Health Services
- ☐ Off-site Program _____

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3. Expiration Date: 3 months or as stated – 1 year

H.S.C. S.K.I.L.L.S. Centres

Physical Exercise & Activities Consent Form

The following individual would like to participate in our various physical activity programs, e.g. bowling, swimming, sports, treadmill, elliptical, bicycle and low impact aerobics. Your input will be beneficial as there may be medical conditions, which preclude this individual's participation. FYI these programs are all staff supervised.

Name: _____

HSC Home: _____ **Telephone: (____)** _____

Health and Physical Activity Readiness

Heart condition yes ____ no ____
If yes, specify: _____

Chest pain during activity yes ____ no ____

Chest pain at rest yes ____ no ____

Dizziness, vertigo yes ____ no ____

Bone or joint problem yes ____ no ____
If yes, specify: _____

Blood pressure problems yes ____ no ____
If yes, circle **high** or **low** blood pressure

Other reason that would affect physical activity participation yes ____ no ____
If yes, specify: _____
_____

Medications for: Heart yes ____ no ____ B. P. Problems yes ____ no ____
Other yes ____ no ____

Recommended activities:

___ Sedentary/relaxation: e.g. sauna, hot tub
___ Very Light Effort: strolling, etc.
___ Light Effort: e.g. slow-paced walking, volleyball, easy gardening, stretching, badminton, Tai Chi, bowling
___ Moderate Effort: e.g. treadmill, stationary bicycle, brisk walking, baseball, swimming, dancing, water aerobics
___ Vigorous Effort: e.g. aerobics, jogging, basketball, lap swimming, energetic dancing, floor hockey

Comments:

This individual is **able/not able** to participate in physical activities through their chosen programs with the Homes for Special Care S.K.I.L.L.S. Centre.

Physician signature Date

If you would like to speak with someone about this form or content, contact Martha Loewen, cell phone (905) 536 – 3915.