REFERRAL FOR PARTICIPATION and CONSENT

Personal information on this form is collected under the authority of the City of Mississauga bylaw 0282-2011. The personal information will be used for the purposes identified below. Questions about this collection should be directed to the **Program Coordinator, South Common Community Center, 2233 South Millway, Mississauga, Ontario L5L 3H7, and Telephone: 905-615-4770 x2279**

Name: _____ **Health Card Number**: _____

The Next Step to Active Living is a Therapeutic Recreation program linking adults with acquired physical disabilities to an active independent lifestyle within the community. **Acceptance to the Next Step to Active Living Program ("Program") requires physician approval.**

By signing this form where indicated below, you acknowledge, understand and agree that The City of Mississauga ("**City"**) may be collect, use and disclose: i) the information provided herein, including health card number; and ii) personal health information that you provide to the City from time to time related to the Program for the following purposes or for a consistent purpose:

- To provide the Program services to you and share with Home and Community Care to provide its services to you.
- To authorize your physician to provide the information requested below to the City of Mississauga for use in the Program and to Home and Community Care for the purpose of providing services to you.
- To propose and with your consent, provide additional services that may be appropriate for you from time to time.
- To consult with your healthcare providers about your health; and
- To comply with and as permitted by the *Municipal Freedom of Information and Protection of Privacy Act* ("**MFIPPA**") and applicable privacy laws and regulations

Participant Signature: _____ Date: _____

Site: South Common ☐ Huron Park ☐

PARTICIPANT INFORMATION

Name: _____ ☐ Male ☐ Female

Address: _____

City: _____ Postal Code: _____

Telephone (DAYTIME):_____

Date of Birth: ____/____/____ Trans Help#: _____

dd mm yy

Revised August 2020

Emergency Contact: _____ Relationship: _____

Daytime Telephone Number: _____

Referred By: ☐ THP – CVH ☐ THP – MISS ☐ Self ☐ Other_____

Referral Name: _____Telephone: _____Fax: _____

Please complete the following sections, where applicable:

Goals in participating in the program:

1._____

2._____

PHYSIOTHERAPY

Ambulates: _____ meters ☐ Independently: ☐ Min. Supervision: ☐ Max. Assistance:

Gait Aid: ☐ No Gait Aid ☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter

Supervision Required: _____

Contraindications: _____

_____

Pool Experience: ☐ Yes ☐ No

Exercise Program: _____

_____

OCCUPATIONAL THERAPY

Cognitive Ability: _____

_____

Physical Function: _____

_____

Personal Care: _____

_____

SPEECH THERAPY

Areas of Difficulty: _____

_____

Goals and Strategies: _____

_____

PHYSICIAN'S SECTION (PLEASE PRINT)

Primary Diagnosis: _____ Date: _____

Secondary Diagnosis: _____Date: _____

Medical History: _____

_____

History of falls: NO:_____ Yes: ____ Please explain: _____

_____

PHYSICIAN'S CONSENT: (PLEASE PRINT)

_____ may participate in the Next Step to Active Living Program with the following guidelines:

☐ Unrestricted physical activity (starts slowly and builds up gradually)

☐ Progressive physical activity with avoidance of _____

☐ Progressive physical activity with inclusion of _____

- **Is Current Blood Pressure well managed:** ☐ Yes ☐ No
- **Seizure:** ☐ Yes ☐ No If yes, How would this impact on the involvement in the program?

  _____

Allergies: ☐ Yes ☐ No If yes, please specify: _____

_____

Diabetic: ☐ Yes ☐ No Is Diabetes well managed? ☐ Yes ☐ No

Continent: ☐ Yes ☐ No Additional Information: _____

_____

Would you recommend use of?

Hot tub (40° Celsius): ☐ Yes ☐ No **Sauna:** ☐ Yes ☐ No

Doctor's Stamp:	Doctor's Signature: _____ Date: _____

Revised August 2020