Volunteer/Community Support Services

SMART GROUP INTAKE FORM

VON CANADA
HEALTH STARTS AT HOME

INTAKE INFORMATION			Service Type:	
Mr./Mrs/Ms	First Name:		Last Name:	
Address:			**Apt #:**	
City:			**Postal Code:**	
Home Phone:			**Cell Phone:**	
Health Card Number:		VC:	**Email:**	
Birth Date: *(m/d/y)*			**Gender:**	☐ Male ☐ Female
Language Spoken:	☐ English	☐ French	☐ Other:	
Referral Source:				

EMERGENCY CONTACTS (phone number should differ from client's)

Name:	Relationship:
Day #:	Home/Cell:
Name:	Relationship:
Day #:	Home/Cell:
Family Doctor: Phone:	Name of substitute decision maker:

Health Status- Conditions affecting Activities of Daily Living (ADLs)

o Stroke	o Breathing	o Diabetes	o Heart Condition
o Arthritis	o Osteoporosis	o Carpal Tunnel Syndrome	o High Blood Pressure
o Low Blood Pressure	o Memory Problems	o Contagious Diseases	o Mental Health
o Epilepsy	o Hearing impairment	o Vision impairment	o Cancer
o Environmental Allergies o	o Medical Allergies	o Food Allergies	
o Other			
Injury to:	o **Shoulder**	o **Wrist**	o **Back**
	o **Hip**	o **Knee**	o **Other**
Mobility:	o Independent	o Cane/Walker	o Wheelchair/Scooter

INFORMATION TO BE REVIEWED WITH NEW CLIENT

I have reviewed the following information with client:

Discussed with client the importance of talking to their doctor about participating in the SMART Exercise Program ☐ Yes ☐ No

☐ Consent to Service	☐ Written	☐ Verbal	Initials:
☐ Privacy Legislation		Initials:	
☐ Client Bill of Rights & Responsibilities		Initials:	
☐ Complaint process explained		Initials:	
☐ Program Information/Contact number provided		Initials: m.a.	

***I have completed the intake with the client*:**

Date (m/d/y):	Print Name:
Signature:	Initials:
Date (m/d/y):	Print Name:
Signature:	Initials:

Community Support Connections

Meals on Wheels and More

SMART CONSENT & LIABILITY WAIVER

VON CANADA

HEALTH STARTS AT HOME

Name of Participant

Address and telephone number

I realize that there are potential risks inherent in my participation in the SMART Group Program due to the nature of the activity and can occur without any fault. By choosing to take part in this activity, I am accepting the risk that I may be injured. I freely and voluntarily accept and assume all such risks and dangers.

I acknowledge that SMART offers no medical assessment or treatment and that SMART makes no determination as to whether or not I am physically fit to participate in SMART's Group Program. I hereby warrant that I am physically fit to participate in SMART's Group Program.

I accept my responsibility to carefully follow instructions at all times while participating in SMART's Group Program and to abide by all the rules set out by SMART.

I am aware that at any time I may decline to participate in part of, or in the entire Group Program. I accept full responsibility for my level of participation. I acknowledge my obligation to immediately inform the facilitator of any pain, discomfort, fatigue or any other symptoms that I may suffer during and immediately after my participation. I understand that I am encouraged to ask questions or request further explanation about the SMART Group Program at any time.

I agree that SMART, CSC and VON shall not be liable for any injury to my person or loss or damage to my personal property arising from or in any way connected to my participation in SMART's Group Program.

I ACKNOWLEDGE THAT I HAVE READ THE ABOVE, I UNDERSTAND THAT IN PARTICIPATING IN THE ACTIVITY DESCRIBED ABOVE I AM ASSUMING THE RISKS ASSOCIATED WITH DOING SO.

Signature of Participant

Date

CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____, have received and reviewed VON Canada's Statement of Information Practices.

I understand that VON Canada is seeking my consent to collect, use and/or disclose my personal health information in order to provide me with health care or assist in the provision of health care to me. I had an opportunity to have my questions answered regarding these practices. I understand that VON Canada will only collect, use and disclose my personal health information with my consent, unless a particular collection, use or disclosure is permitted or required by law without my consent.

I hereby authorize VON Canada to collect, use and disclose my personal health information for the purposes set out above.

OR

I hereby authorize VON Canada to collect, use and disclose the personal health information of: _____ for the purposes set out above.
(Name of the person for whom you are the Substitute Decision Maker (SDM))

I understand the purpose for which my personal health information is being collected, used and disclosed. I understand that I can refuse to sign this consent form or later withdraw my consent.

Name: _____

Mailing Address: _____ Date of Birth: _____

City, Province _____ Postal Code: _____

Home Phone: _____ Cell / Work Phone: _____

_____ _____
Signature Date

If Applicable

Relationship of SDM to Client: _____

Identification/Evidence Provided by SDM: _____

_____

_____ _____
Printed Name of Witness *Signature of Witness*

_____
Date