South Common ☐
Huron Park ☐

Contact Information
Phone: 905 615-4770 Ext.2279
Fax: 905 615-4772

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: _____

PARTICIPANT INFORMATION

Name: _____ ☐ Male ☐ Female

Address: _____

City: _____ Postal Code: _____

Telephone (DAYTIME):_____

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

dd mm yy

Revised Aug 2018

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

Would you recommend use of?

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

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

Revised Aug 2018

Name: _____

Health Card # : _____

Inter-RAI Preliminary Screener Assessment Information Consent

Your privacy is important to us. As part of the registration process for the "Next Step to Active Living" program (the **"Program**") you have consented above to provide the "**City" or "WE"** with some basic personal health information, including your own assessment of your current health status and details of recent hospitalizations and treatments, we refer to all of the information that you provide to the program / city as your **"Assessment Information"** and we are seeking your consent to collect, use and disclose this Assessment Information as described below.

In accordance with MFIPPA and applicable law the City works to ensure that your Assessment Information is used only for the purposes for which it is collected and for which you have provided your consent or for a consistent purpose.

You have the right to withhold or withdraw your consent to collection, use and disclosure of your Assessment Information at any time and the right to refuse to sign this consent form.

By selecting **"YES I CONSENT"** and signing this form where indicated below you acknowledge understand and agree that the City may collect, use and disclose your Assessment Information for the following purposes or for a consistent purpose.

- To enter your Assessment Information into a secure electronic computer system shared by health information custodians such that your Assessment Information maybe:
  - Accessible to health information custodians (including but not limited to, your physicians, home health service providers, Home and Community Care and healthcare facilities as applicable);
  - Used by health information custodians for the purpose of providing healthcare to you.
- To provide the services you have authorized the City to provide for you.
- For the purpose of government reporting, reporting to health information custodians and for healthcare research.
- To propose and with your consent, provide additional services that maybe appropriate for you from time to time.
- To consult with your healthcare providers about your health
- To comply with and as permitted by, MFIPPA and applicable privacy laws and regulations

By selecting **"YES I CONSENT**" and signing this form where indicated below, you also acknowledge, understand and agree that:

- In addition to collecting your Assessment Information from you directly, the City may also collect your Assessment Information from your healthcare providers and other health information custodians for the purposes described in this consent or for consistent purposes.
- The City may from time to time transfer your Assessment Information to external service providers who provide data storage and processing facilities necessary for the City to operate the Program. Those service providers are obligated to maintain the confidentiality and security of all information entrusted to them. Only authorized employees and entities are permitted to access this information.
- Your Assessment Information may be retained on file after you cease to be registered in the Program for as long as is necessary to allow you to exhaust any recourse that you may have under MFIPPA and

applicable privacy laws with respect to any request for access you may make for this information, unless a longer period is permitted by law.

- The City will take reasonable steps to ensure that your Assessment Information is secure, accurate and up to date and complete.

Please make the following choice and sign where indicated below:

☐ Yes, I consent	☐ No, I don't consent	To the collection, use and disclosure of my Assessment Information as described in this consent form**.** If I have selected **"YES, I CONSENT**", I understand that my choice will only be applied to the sharing of my **Assessment Information** with health information custodians by a secure electronic computer system. Note: This consent does *not* apply to any copies of other information or assessments that other health information custodians may have previously received about you.

Name: _____

Signature: _____ **Date:** (MM/DD/YYYY) _____

Substitute Decision-Maker (if applicable):

Name: _____ _____

Signature: _____ **Date:** (MM/DD/YYYY) _____

Client/Patient Information (information is collected for patient identification) The fields below are used for the purposes of identifying the individual who is consenting so that his/her consent can be properly managed.

Name:

Telephone No: **Address:**

NOTE: Subject to applicable statutory restrictions, you may access the information you have provided to the City and request that we make corrections to it. We may charge a reasonable fee for such access. We ask that you provide these requests in writing to: **Next Step to Active Living Program Coordinator at 905-615-4770 Ext 2279**

If you wish to change your consent to share Assessment Information in the electronic sharing system, please contact the **IAR- Consent Call Center: Toll Free 1-855-585-5279 or TTY Toll Free 1-855-973-4446**

Please refer to the brochure for additional information regarding the collection, use and disclosure of your personal health information or contact **The Privacy Commissioner 416-326-333, 1-800-387-0073 or website http://www.ipc.on.ca**