Holland Bloorview
Kids Rehabilitation Hospital

March of Dimes-Holland Bloorview-Grandview: Turning Point Program Application

Section A – General Applicant Information

Last Name:	Initial:	First Name:

Address *(#, Street, Unit #)*:

City/Town:	Province:	Postal Code:

Gender: ☐Male ☐Female	Date of Birth *(mm/dd/yy):*	Home Telephone: ( )

Health Card No.:

Section B – Emergency Contact Information

Emergency Contact Name:	Relationship to Applicant:

Address:

City/Town:	Province:	Postal Code:

Home Telephone: ( )	Other Telephone: ( )

Section C - Description of Injury and Disability:

Code *(for office use only)* :

Date of Injury (year):

Detailed description of injury and disability:

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Section D – Medical Information

Do you experience seizures: ☐Yes ☐No

Date of last seizure:

Please list any allergies:

Section E – Assistive Devices

Do you use an assistive device?: ☐Yes ☐No

IF YES, which of the following do you use?:
☐ Cane ☐Crutches ☐Walker ☐Braces ☐Manual Wheelchair ☐Electric Wheelchair

IF YOU USE A WHEELCHAIR, are you able to walk to some extent with assistance?: ☐Yes ☐No

NOTE: This program does not provide medical care such as dialysis treatments. It is a life skills and recreation program that provides attendant care services if required. Participants must be able to self-direct their own medication.

Section E – Activities of Daily Living and Personal Care Requirements

Please indicate the level of assistance that you require for each of the activities below.
Accuracy in filling out this section is essential to the planning of your care

Task	Total Assistance (75-100%)	Some Assistance (25-75%)	No Assistance (0-25%)
Eating	☐	☐	☐
Brushing teeth	☐	☐	☐
Washing hands/face	☐	☐	☐
Grooming (shaving)	☐	☐	☐
Dressing (upper body)	☐	☐	☐
Dressing (lower body)	☐	☐	☐
Showering / bathing	☐	☐	☐
Toileting	☐	☐	☐
Transferring:			
On and off the toilet	☐	☐	☐
In and out of the bathtub	☐	☐	☐
In and out of bed	☐	☐	☐
In and out of a wheelchair	☐	☐	☐

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IF YOU NEED ASSISTANCE WITH TRANSFERRING, please indicate your preferred method:

☐Hoyer ☐2-person transfer ☐1-person transfer

Do you require:

Turning at night?	☐ Yes	☐ No	IF YES, how many times?:
A Hospital Bed?	☐ Yes	☐ No	
Do you use a G-Tube?	☐ Yes	☐ No	

Do you have control of your:	Do you use:	Night-time help required?	Do you require:	Do you use:
☐ Bowels	☐ Toilet	☐Yes ☐No	☐ Catheter irrigation	☐ Attends
☐ Bladder	☐ Commode chair	☐Yes ☐No	☐ Disempaction	☐ Condom drainage
☐ Neither	☐ Bed pan/ urinal	☐Yes ☐No	☐ Enemas ☐ Laxatives	☐ Colostomy
			☐ Suppositories	☐ Ileoconduit
				☐ Catheter: Type:

Section F – Communication

(a) Do you wear hearing aids? ☐Yes ☐No

(b) Do you have speech difficulties? ☐Yes ☐No

IF YES to (a) or (b) above, how do you communicate?:

☐ Verbal ☐Bliss board, symbol or picture board ☐Sign language ☐Other (specify):

Section G – Social Development

Choose one of the following options below to describe your social interactions:

☐ No difficulties functioning in social situations
☐ May need prompting and encouragement when getting involved in new experiences
☐ Poor socializing skills – needs complete supervision in social situations

Choose one of the following options below to describe your decision-making skills:

☐ Independent (no assistance necessary)
☐ Need moderate prompting
☐ Need total assistance

Choose one of the following options below to describe your cognitive reasoning skills:

☐ Clearly understand directions and respond accordingly
☐ Need some direction and further explanation at times
☐ Often experience confusion with comprehending minimal tasks

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Section H – Transportation (Applicants not residing in the Durham Region)

Transportation to and from the retreat is the responsibility of the participant

Section I – Retreat Date and Program Fee

Program Date:
July 7 to July 11, 2014

Fee: $500.00 *(MONEY ORDER OR CHEQUE - made out to **March of Dimes Canada**)*

The program fee includes: accommodation, meals, and recreational activities.

The full program fee **will be due upon acceptance to the program.**

Cancellation Policy:
If your cancellation is due to illness, you will be reimbursed in full. Other cancellations are subject to a $20.00 processing fee.

Section J: Verification and Signature

I verify that the information that has been given in this application is complete and accurate to the best of my knowledge. I agree to abide by the rules of the retreat and to conduct myself in a socially appropriate manner, and I understand that failure to so may result in my being asked to leave the retreat.

Applicant/Substitute Decision Maker Signature:	Date *(mm/d/yy)*:

Please return this form to:

March of Dimes Canada
Attn: Lori Wood
13311 Yonge St., Suite 202
Richmond Hill, ON. L4E 3L6
lwood@marchofdimes.ca
Phone 905-773-7758 Ext. 6225
Fax: 905-773-5176

The deadline for applications is Friday March 21, 2014,

Please note that submitting an application does not guarantee acceptance.
A telephone interview will be conducted with each applicant.
Program acceptances will be confirmed by March 28, 2014.