The War Amps

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Adult Amputee Program Enrolment

Who is completing the form? _____

Information About the Amputee

_____ _____ _____
First name Middle name(s) Last name

Preferred name: _____ Other last name(s) previously used (optional): _____

Date of birth: _____ Gender: _____ Preferred pronouns: _____
day/month/year

Address: _____

City: _____ Province: _____ Postal code: _____

For confidentiality and privacy purposes, all mail from The War Amps will be mailed to you at this address.

Phone number: _____ Email: _____

Please state your language preference: ☐ English ☐ French

How did you learn about The War Amps services for amputees?

_____

_____

Type of Amputation(s)

Please select all amputation types that apply and indicate the location (for bilateral amputations, check both left and right). Provide the cause (at birth, medical or accident) and date of each amputation.

	Left	Right	Cause	Date
Transtibial (below the knee)	☐	☐		
Transfemoral (above the knee)	☐	☐		
Partial foot	☐	☐		
Syme's	☐	☐		
Ankle disarticulation (through the ankle)	☐	☐		
Knee disarticulation (through the knee)	☐	☐		
Transradial (below the elbow)	☐	☐		
Partial hand	☐	☐		
Wrist disarticulation (through the wrist)	☐	☐		
Transhumeral (above the elbow)	☐	☐		
Elbow disarticulation (through the elbow)	☐	☐		
Hemipelvectomy	☐	☐		
Hip disarticulation (through the hip)	☐	☐		
Rotationplasty	☐	☐		
Forequarter	☐	☐		
Shoulder disarticulation (through the shoulder)	☐	☐		

Other (please specify): _____

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The amputation(s) is/are the result of a limb length discrepancy of the: ☐ Femur and/or ☐ Tibia/Fibula

The amputation(s) is/are the result of a limb length discrepancy of the: ☐ Humerus and/or ☐ Radius/Ulna

The limb length discrepancy is: _____ cm or _____ inches

Additional notes: _____

Cause(s) of Amputation

Please select all that apply and provide the date(s) of each amputation or surgery, if applicable.

At birth

Congenital ☐

Congenital surgical ☐
(As a result of congenital limb deficiency where surgical amputation has been or will be required)

Congenital type:

No cause or diagnosis ☐
Amniotic band syndrome ☐
Fibular hemimelia ☐
PFFD ☐
TARS ☐
Other ☐

Please specify: _____

Medical

Date of diagnosis: _____

Cancer ☐
Meningitis ☐
Diabetes ☐
Vascular ☐
Sepsis ☐
Other ☐

Please specify: _____

Accident

Date of accident: _____

Automobile accident ☐
Farm accident ☐
Lawn mower ☐
Train accident ☐
Electrocution ☐
Frostbite ☐
Grinder accident ☐
Workplace accident ☐
Miscellaneous accident ☐

Please specify: _____

Date(s) of amputation(s)/surgery or surgeries (if applicable): _____

_____

_____

Are you considering pursuing legal action as a result of the cause of amputation (if applicable)? ☐ Yes ☐ No

Please indicate the prosthetic/rehabilitation centre you attend: _____

Is a prosthetic limb/device currently being made? ☐ Yes ☐ No

Other Sources of Funding

Are you eligible for funding from any other source, such as social assistance, or do you have personal extended health coverage or group insurance through your place of employment? This will ensure the coverage of artificial limbs is within our funding guidelines.

☐ Yes *Please specify:* _____ ☐ No

One-Time Financial Grant

We understand that adapting to life as an amputee can be a major adjustment. As such, The War Amps is offering a one-time financial grant for new enrollees who may benefit from it during their recovery journey. The grant can be used to help offset the costs associated with becoming an amputee.

This grant is separate from any prosthetic funding support we provide and will not have an impact on the amount eligible for prosthetic care.

Are you interested in applying for this one-time financial grant? ☐ Yes ☐ No

Confirmation of Amputation

To receive this grant, a member of your medical team must complete a form that confirms your amputation level. Medical professionals can only be one of the following:

- Doctor (general practitioner, nurse practitioner, physiatrist)
- Prosthetist
- Occupational therapist
- Physiotherapist

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Once your request for enrolment has been processed and approved, you will receive an email from The War Amps that includes the *Confirmation of Amputation* form that must be filled out and signed by your medical professional and returned to us. You may also download and print the form from our website, **waramps.ca**.

Once the confirmation is received, a cheque will be sent to the address provided in your enrolment form. We are not able to send funds via direct deposit at this time.

Release

In consideration of The War Amputations of Canada assisting me through the Program, I, _____, hereby release and forever discharge The War Amputations of Canada of any fault from all claims, demands, damages, actions or causes of action arising, or to arise, whatsoever in law or in equity which I, my heirs, executors, administrators or assigns can, shall or may have because of my involvement in the Association's activities and functions.

Further, I agree to indemnify and save harmless The War Amputations of Canada and their successors and assigns against and from all actions, damages, debts, accounts, claims and demands that may hereafter be brought against them by me or on my behalf because of my involvement with the Association's programs.

_____ _____

Member (print name) Witness (print name)

_____

Email

_____ _____

Member's signature Witness' signature

Date: _____ Date: _____

day/month/year day/month/year

Application Signature

Applicant's signature _____ Date: _____

day/month/year

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Consent to Release Information to a Third Party

I acknowledge that The War Amps may need to communicate personal information to a third party in order to provide requested services. Before or at the time The War Amps collects or accesses personal information, the Association will explain the information's intended use. Unless required by law, The War Amps will not use or disclose any personal information that has been collected without documenting the new purpose and obtaining further consent. A photocopy or electronic version of this authorization is as valid as the original. This permission is valid until I withdraw my consent in writing.

I/We authorize The War Amps to release my/our personal information relating to requested services such as accommodation, travel, shipping and special requirements to third parties.

Applicant (print name) _____

Applicant's signature _____

Date: _____
day/month/year

The information collected by The War Amps is for the purpose of funding your needs and providing you with the services you have requested. The War Amps is committed to protecting the privacy of your personal information. Information collected may be processed by a third-party service provider.
Charitable Registration No.: 13196 9628 RR0001