|  |
| --- |
| **Personal Information** |
| Last name:  | First name:  | Gender:  |
| Address: |
| Telephone home:  | Cell:  |
| Languages spoken:**[ ]** English**[ ]** French**[ ]** Other:  |
| Primary contact for Visiting Buddies purposes:[ ]  Client[ ]  Caregiver (provide caregiver information on page 2) |
| **Availability for visits** |
| **[ ]** Monday**[ ]** Tuesday**[ ]** Wednesday**[ ]** Thursday**[ ]** Friday**[ ]** Saturday**[ ]** Sunday | **[ ]** mornings**[ ]** afternoons**[ ]** evenings |
| I am not available on the following days/at the following times: |
| **Experience & interests** |
| Past occupation(s):  |
| Skills, interests, or hobbies that may be pertinent to the volunteer visitor: |
| **Living situation** |
| The client lives**[ ]** Alone**[ ]** With spouse[ ]  With family? |
| Is the client widowed?[ ]  No[ ]  YesNotes: |
| Does the client smoke?[ ]  No [ ]  YesNotes:  |
| Is there a pet in the home?[ ]  No [ ]  YesIf yes, type of pet:  |
| **Caregiver information (if applicable)** |
| Caregiver first name: | Caregiver last name: |
| Caregiver phone: | Caregiver email: |
| **Medical information**  |
| **[ ]** Limited/compromised mobility[ ]  Dementia[ ]  Hearing challenges[ ]  Speech challenges | **[ ]** Incontinence **[ ]** Impaired vision[ ]  None of the above |
| Other health concerns: |
| Is client on a list for Long Term Care (LTC)?[ ]  Yes[ ]  No |
| Other health services in the home:[ ]  Personal Support [ ]  Nursing[ ]  PT (Physio)[ ]  OT (Occupational Therapy)[ ]  None[ ]  Other:  |
| Most involved Physician:Name:Phone:  |
| **Emergency contact** |
| First name: | Last name:  |
| Relationship to client: |
| Main phone: | Alternate phone: |
| **Other information** |
| How did you hear about this program? [ ]  Eastern Shore Cooperator advertisement [ ]  Poster[ ]  Newsletter [ ]  Website[ ]  Social media [ ]  Word of mouth[ ]  Other |
| **Authorization for collection of Personal Information**I authorize the Well-Being HUB to collect personal information appropriate to the service/program I am applying for. I understand that the information obtained will be kept confidential. I hereby certify that the above information is true to the best of my knowledge. I agree to keep the Well-Being HUB informed if any of the above information changes at any time. I understand that any willful falsification of information may result in termination of my access to the service being provided. |
| **Signature:**  | **Date:**  |
| **Thank you for your interest in participating in the** **Well-Being HUB’s Visiting Buddies Program!** |