

Thank you for your interest in Conductive Education®.

Conductive Education® is a community rehabilitation program offered through March of Dimes Canada, whose mission is to maximize the independence, personal empowerment, and community participation of people with disabilities.

Designed specifically for people with neurological motor disorders, Conductive Education® offers an alternative group setting approach to rehabilitation for people living with Cerebral Palsy, Spina Bifida, Multiple Sclerosis, Stroke, Parkinson's, and Acquired Brain Injury

Thousands of Canadians are diagnosed with the above conditions each year, and Conductive Education® and March of Dimes Canada are here to offer help and support to these individuals and their families.

Everyone involved in Conductive Education® knows that progress is possible, regardless of age, disability, or the amount of time since diagnosis, and it is this shared belief that creates a positive, motivating, and inspiring environment which is conducive to learning.

In Conductive Education®, each person is viewed and treated as an individual, with individual needs and circumstances. As such, there is no "one size fits all" approach to attendance. No referrals are required for the program and a conductor will be able to make a recommendation regarding attendance after an initial consultation has been held.

A completed application form is required for each adult that attends the CE program. Conductors use this information to assess and place the individual in the appropriate group and to prepare the task series for each individual in advance of their attendance. All information collected will be kept confidential. Please print your name and the signatory initials on the top of each page.

How do I get involved?

- After submitting this application form, a member of the CE team will contact you to set up an initial consultation. (Contact information is listed below)
- At the initial consultation, the team will meet with you to explain more about the CE program. At the consultation we will go through a series of movements to see where you with your movements, and talk about aims that can be set, if you choose to attend the program. A full consultation report is written and will be shared with you.
- CE is currently not covered by health and insurance plans.

#### **Toronto, Ontario Location:**

Where are CE Sessions held? Toronto, ON



This form can be mailed, faxed or emailed to our CE team at:

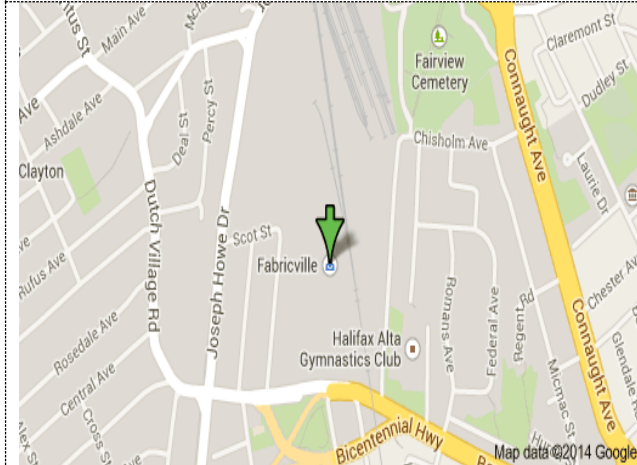
Mail:  
March of Dimes Canada  
Conductive Education® Program  
10 Overlea Boulevard  
Toronto, ON M4H 1A4

Fax: 1-416-425-1920,  
Attention: Conductive Education® Team  
Email: [ce@marchofdimes.ca](mailto:ce@marchofdimes.ca)  
Phone: 1-800-263-3463 / 416-425-3463, ext. 7262

Participant's Name:

Signatory Initials:

**Halifax, Nova Scotia Location:**

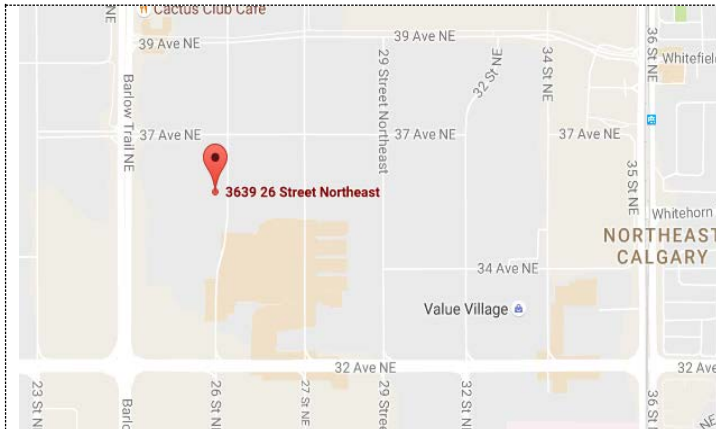


This form can be mailed, faxed or emailed to our CE team at:

**Mail:**  
 March of Dimes Canada  
 Conductive Education® Program  
 7071 Bayers Road, Suite 276  
 Halifax, NS B3L 2C2

**Fax:** 902-444-3692  
**Attention:** Conductive Education® Team  
**Email:** [ce@marchofdimes.ca](mailto:ce@marchofdimes.ca)  
**Phone:** 902-444-1090

**Calgary, Alberta Location:**



This form can be mailed, faxed or emailed to our CE team at:

**Mail:**  
 March of Dimes Canada  
 Conductive Education® Program  
 3639 26 St NE  
 Calgary, AB, T1Y 5E1

**Fax:** 403-263-8954  
**Attention:** Conductive Education® Team  
**Email:** [ce@marchofdimes.ca](mailto:ce@marchofdimes.ca)  
**Phone:** 403-473-4920

Thank you for considering the CE program through March of Dimes Canada. We look forward to working with you and helping you achieve greater independence.



Participant's Name:	Signatory Initials:
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**Consumer Information**

<b>First Name:</b>	<b>Initial(s):</b>	<b>Last Name:</b>
<b>Name Commonly Used:</b>		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Address:</b>		
<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>
<b>Date of Birth (mm/dd/yy):</b>		<b>Health Card No.:</b>
<b>Home Phone:</b>	<b>Email:</b>	
<b>Work Phone:</b>		<b>Cell:</b>

**Living Situation:**  Independent Living  Lives with Family  Supported Living

<b>Diagnosis Information</b>	<b>Emergency Contact Information</b>
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<b>Diagnosis:</b>	<b>Name of Contact:</b>
	<b>Relationship to Applicant:</b>
	<b>Home Phone:</b>
<b>Date of Diagnosis (mm/dd/yy):</b>	<b>Work Phone:</b>
	<b>Cell Phone:</b>
	<b>E-mail:</b>



Participant's Name:

Signatory Initials:

**Symptoms and Manifestation of Disorder**

**Diagnosis: Parkinson's Disease**

Has anyone in your family had the same diagnosis? *(if yes, please specify)*  Yes  No

Which side of your body has been more affected:  Left  Right  Both

<b>Do you experience:</b>	<b>Comments</b> <i>(if checked yes for any of the following, please give details and explain how your daily activity is affected)</i>	
<b>Tremor</b>  If yes, where:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Stiffness:</b>  If yes, where:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Slowness of movement?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Postural changes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Freezing</b> (suddenly stop and can't move)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Dyskinesia</b> (involuntary movements)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Visual problems</b> (double vision, vision loss, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Falling</b>  If yes, how frequently:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Lack of facial expression</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Pain</b>  If yes, where:  Rating 1-5 <i>(5 being the worst)</i> :	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Speech or breathing problems</b> (volume, articulation, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Difficulty with writing</b> (micrographia, dyskinetic writing, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Across your drug cycle is there any significant variation in your condition?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Additional symptoms or comments:**



Participant's Name:	Signatory Initials:
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**Daily Activity** (please mark the appropriate box)

Are you able to...?	Not at all	With help	On your own with difficulty	On your own easily	Comments
Sit up from bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weight bear transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transfer (e.g., bed to chair)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Turn over in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stand up from a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Get up from the floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walk around outside in summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walk around outside in winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walk over uneven ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cross the road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Get in and out of a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Travel on public transit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do your own housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do your own cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Self -Care Activities** (please mark appropriate box)

Are you able to...?	Not at all	With help	On your own with difficulty	On your own easily	Comments
Dress upper body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dress lower body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Undress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Participant's Name:	Signatory Initials:
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**Health Conditions**

**Please check either yes or no, and provide any details related to the condition:**

Condition		Additional Details
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Colds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies (please describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures (please describe frequency, type and any medical procedures)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Other Information**

Surgery (please specify type and date)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use any assistive devices	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify type:
Do you wear glasses or contact lens	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, why:
Do you have difficulty hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, do you use hearing aids: <input type="checkbox"/> Yes <input type="checkbox"/> No

Participant's Name:

Signatory Initials:

**Other Factors**

1. **Rehabilitation** – please describe any rehabilitation treatment that you are receiving for your condition (e.g., physiotherapy, OT, speech therapy, personal trainer, yoga, pilates, etc.)

2. **Physical/Psychological** - Please state any physical or emotional concerns, and detail any other information that you feel should be made known to the conductors:

**3. Communication Methods**

a. First Language:

b. Speech:  Clearly understood  Slightly difficult to understand  Few Words  Non-verbal

c. Communication Device: Please list any communication devices you use

d. Other Communication Methods (please describe):

4. **Occupation:** What is your current and/or previous occupation(s):

If required, do you have a caregiver/friend who could attend with you  Yes  No

How did you hear about Conductive Education® at March of Dimes Canada?

Friend  Advertisement  Internet (Social Media/Website)

Other – *please specify:*

**Declaration and Signature**

I hereby state that the above information is true to the best of my knowledge

Signature:

Date (mm/dd/yy):

Participant's Name:	Signatory Initials:
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**Liability, No Action, Indemnity Clauses: Release**

**Please read and sign the following Exclusion of Liability, No Action and Indemnity clauses. By signing below, you will waive certain legal rights, including the right to sue. Please read carefully.**

In consideration of the services to be provided to me by March of Dimes Canada, I hereby agree as follows:

1. **EXCLUSION OF LIABILITY**--not to hold March of Dimes Canada, their members, directors, volunteers, officers, agents, representatives, employees, or assigns ("Releases"), or any of them, liable for any losses, damages or injuries that I may suffer, whether to person or property, howsoever caused, including negligence, breach of contract and breach of any statutory duty or other duty of care, on the part of the Releases, or any of them;
2. **NO ACTION**--not to bring any action, proceedings or claims against the Releases, or any of them, for any losses, damages or injuries that I may suffer, whether to person or property;
3. **INDEMNITY**--to indemnify and hold harmless the Releases and each of them from and against all claims, actions, costs, expenses and demands brought by any person in respect of death, injury, loss or damage, whether to person or property, resulting directly or indirectly from my participation with the Releases and the delivery of the projects and services of March of Dimes Canada.

**Declaration and Signatures**

- I have read and understood this agreement, and I am aware that, by signing this agreement, I am waiving certain legal rights which I or my heirs, next of kin, executors, administrators, and assigns may have against the Releases.
- I hereby release and hold harmless all March of Dimes Canada and any and all other funding or organizations and sources, the owners and/or operators of any facilities utilized and any providers/ conductors of instruction, the agents and employees of any of these parties, from all liability and claims for any injuries or accidents to myself, as well any damages from any cause to any personal property that may occur while participating in the said Conduction Education ® Program.

<b>Full name of applicant:</b>	<b>City:</b>	<b>Date:</b>
<b>Applicant's Signature:</b>	<b>Witness:</b>	
<b>Spouse/Caregiver Signature:</b>	<b>Witness:</b>	