

ACTIVE LIVING PROGRAM

WELCOME TO THE ACTIVE LIVING PROGRAM!

Attached you will find:

1. General Information – Regarding Active Living Program
2. Application Form (Page 3)
3. Participant Release Form (Page 4)
4. Physician Medical Clearance Form (Page 5)

Please forward completed forms and fees to:

**Sunnybrook Health Sciences Centre
St. John's Rehab - Outpatient Services
285 Cummer Ave.
Toronto, ON
M2M 2G1**

You can also Fax your completed forms to 416-226-3358 or drop it off at our Outpatient Services Admin Office (8:00 a.m. to 4:00 p.m.)

If you have any questions, feel free to call us at:

416-226-6780 x 57215



ACTIVE LIVING PROGRAM

Please call 416-226-6780 x 57215

Program Description:

The Active Living Program is an 8 week generalized exercise class focused on improving balance, strength, flexibility and conditioning. Participants will exercise and target muscles and joints in the legs, arms and core. Exercises, although very effective, are simple enough for you to repeat at home. Participants need to be highly independent, able to follow instructions and be medically and cognitively safe to participate in a group based exercise class.

Program Schedule:

Tuesdays	Thursdays
1:00 p.m. - 2:00 p.m.	11:00 a.m. - 12:00 p.m.

* Dates are subject to change due to revision of hospital schedules and/or other unforeseen circumstances.

* Participants' class time preference will be based on availability.

Acceptance to the program is subject to:

1. Completion and review of all forms
2. Receipt of payment
3. Availability

Fee Schedule:

- \$110 per session. Each session includes 8 classes. Classes are 1 hour in duration. Please provide a cheque with your application made payable to: **Sunnybrook Health Sciences Centre**. If you wish to use another method of payment you will be sent an invoice in the mail and can call Patient Accounts at: 416-480-4156
- **There are no refunds or make-up classes for missed sessions**
- The fee includes all exercise classes and TheraBand®. Please wear comfortable clothing and running shoes and bring a bottle of water.
- You may only attend class on your scheduled days.



ACTIVE LIVING PROGRAM

Application Form

Name: Last name, first name	Date of Birth YYYY/MM/DD	OHIP Number:
Address:		
Home Phone:	Alternate Phone:	
Emergency Contact Name: Last name, first name	Emergency Contact Phone:	

Please indicate which session(s) you would prefer:

Tuesdays	Thursdays
<input type="checkbox"/> 1:00 p.m. - 2:00 p.m.	<input type="checkbox"/> 11:00 a.m. - 12:00 p.m.
<input type="checkbox"/>	<input type="checkbox"/>

Please indicate the following with a (✓):

	With a cane	With a walker	Without any walking aids	No
1. Are you able to walk independently?				
2. Are you able to walk up and down stairs?				
3. Are you able to stand up from a seated position?				

How often do you exercise right now?

- ☐ Less than 1 time per week
 ☐ 1 to 2 times per week
 ☐ 2 to 3 times per week
☐ 3 to 4 times per week
 ☐ More than 5 times per week

What type of exercise(s) do you do?

- ☐ Walking
 ☐ Running/jogging
 ☐ Hiking
 ☐ Swimming
 ☐ Gardening
☐ Dancing
 ☐ Yoga/Pilates
 ☐ Cycling
 ☐ Other: _____

When you exercise, do you experience any of the following?

Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain _____ _____ _____ _____
Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Legend: OHIP - Ontario Health Insurance Plan



ACTIVE LIVING PROGRAM Participant Release Form

Participants Name: (PRINT) _____
Last name, first name

- ☐ I understand and agree that, except for its gross negligence or willful misconduct, Sunnybrook Health Sciences Centre (including St. John's Rehab) does not assume and expressly disclaims liability for any personal injury or property damage I may suffer during or resulting from participation in the Active Living Program and that participation is at my own risk.
- ☐ I understand that acceptance into the Active Living Program is based on availability, suitability and subject to review of completed forms and payment received.
- ☐ I understand that I am responsible for reporting to the physiotherapy assistant teaching the class at St. John's Rehab any changes in my medical and/or mobility status as it may affect my ability to safely participate in the program.
- ☐ I understand and agree not to attend classes or enter the facility if I am feeling unwell
- ☐ I understand that I will be screened each time I enter the facility and will be provided with a hospital approved mask which I will be required to wear for the duration of my visit

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

To be completed by Outpatient Staff:

Estimated start date: (YYYY/MM/DD) _____ Payment Received: ☐ Yes ☐ No



ACTIVE LIVING PROGRAM

Medical Clearance Form

Participants Name: _____
Last name, first name

The Active Living Program includes 1 hour of gentle exercises in a group-based setting to help improve range of motion, muscle strength, endurance and balance. Exercise intensity ranges from no resistance to light resistance depending on the patient's ability. Exercises are in sitting or standing positions with support. This class is suitable for people who are independently mobile, medically and cognitively stable and are able to follow instructions. The Active Living Program is not designed to focus on any specific impairment or condition.

Please indicate if the participant has any of the following conditions/impairments to help us determine their suitability for the program.

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If applicable, please explain
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epileptic seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	_____
Incontinence issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Limited vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor balance	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other medical conditions/symptoms:

☐ **In my opinion, this participant is medically stable and SAFE to participate in the Active Living Program at St. John's Rehab, a part of Sunnybrook Health Sciences Centre.**

Additional Comments:

Physician Name: Last name, first name	Physician Signature:
Phone:	Date: (YYYY/MM/DD)

For more information or questions please contact us at **416-226-6780 x 57215**
Fax 416-226-3358

