BLUEWATER HEALTH

Physiotherapy Appointment Reminder

PATIENTS NAME

DATE

- Please arrive 15 minutes before your appointment to the main entrance or underground parking off Maria St.
- Proceed directly to the 2nd floor. You do not need to register at Patient Registration.
- You must wear a mask for your visit. Please bring your own, or one will be provided to you.
- Your driver must wait outside the hospital for you. Porters are available to take you to and from your appointment.
- Please bring your Physiotherapy script from your doctor, health card, and gait aid(s) with you.
- Wear comfortable clothing and proper footwear.
- Please complete the attached health questionnaire and Lower Extremity Function Scale, and bring it to your appointment.
- If you are ill or can't attend, please contact us at (519) 464-4416, so we can offer your appointment to someone else.
- Please bring your gait aid(s)

Do Not Attend if You Answer Yes to Any of the Following Questions:

- Have you tested positive for COVID-19?
- Have you had close contact with someone who tested positive for COVID-19 without wearing personal protective equipment?
- Have you travelled outside of Canada in the last two weeks?

Do You Have Any of the Following Symptoms?

New onset cough
Existing chronic cough
Sore throat or Difficulty swallowing
Decrease or loss of sense of taste or smell
Unexplained fatigue/malaise/muscle aches (myalgia)
Nausea/vomiting/diarrhea/abdominal pain
Runny nose or nasal congestion without other known cause

Do Not Attend if You Are Over 70 and Are Experiencing:

- Unexplained or increased number of falls
- New onset of confusion or difficulty thinking
- A change in an existing chronic health condition

You will be screened as above each time you attend an appointment, to minimize the risk to yourself and others

BLUEWATER
HEALTH

Arrival for Appointments (Underground)

Bluewater Health is gradually re-establishing services and programs at the hospital to meet the community's healthcare needs and protect the health and safety of patients and staff. Several changes have been implemented at the hospital in response to the COVID-19 pandemic to keep our patients, staff and hospital environment safe.

You will see physical changes to protect the health of patients and staff, such as how people move through and wait in the hospital to allow physical distancing, as well as increased cleaning. Staff in all areas of the hospital are wearing masks unless they are alone in a room with the door closed or in a designated eating area, appropriately distanced. It is expected no more than four people will share an elevator.

Entering the Hospital through the Underground Parking Garage

The hospital's current visitor and family policy is on our website. We are temporarily limiting visitors and family members of patients to prevent transmission of the virus. There are exceptions to allow one essential support person identified during the appointment booking. Some patient groups will enter the hospital through the entrance in the underground parking garage.

If you are instructed to enter through the underground parking garage entrance:

- Arrive 10 minutes before your scheduled appointment time. If arriving earlier, you may be asked to remain in your car or a suitable location to ensure we are able to maintain physical distancing inside the building.
- Enter the underground parking lot off Maria Street to park – at this time parking is free.
- A greeter will welcome you outside the entrance.
- Hospital staff will ask you to provide appointment information.
- Screeners will ask you about any new cough, fever, or shortness of breath, and whether you've been directed to self-isolate over the last two weeks.
- You will be given instructions about how to safely move through the hospital.
- If you have a mask, please bring it with you. If you don't, we will provide one. You will be expected to wear a mask for the duration of your time in the hospital.

Registering for Your Appointment

Follow the registration instructions you were given at the time of booking. After registering for your appointment, you will proceed to a waiting room until your name is called.

Please note the capacity in waiting rooms has been adjusted to allow for physical distancing and check for signage. This may mean you will be asked to wait in another designated area until you are called or there is capacity in the waiting room for the clinic you are attending.

Name: ______________________________________ **Date:** ___________________

LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

ACTIVITIES **(Circle one number on each line)**	Extreme Difficulty or Unable to Perform Activity	Quite a bit of Difficulty	Moderate Difficulty	A Little bit of Difficulty	No Difficulty
a. Any of your usual work, housework or school activities	0	1	2	3	4
b. Your usual hobbies, recreational or sporting act activities	0	1	2	3	4
c. Getting into or out of bath	0	1	2	3	4
d. Walking between rooms	0	1	2	3	4
e. Putting on your shoes and socks	0	1	2	3	4
f. Squatting	0	1	2	3	4
g. Lifting an object, like a bag or groceries from the floor	0	1	2	3	4
h. Performing light activities	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of car	0	1	2	3	4
k. Walking 2 blocks	0	1	2	3	4
l. Walking a mile	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
n. Standing for 1 hour	0	1	2	3	4
o. Sitting for 1 hour	0	1	2	3	4
p. Running on even ground	0	1	2	3	4
q. Running on uneven ground	0	1	2	3	4
r. Making a sharp turns while running fast	0	1	2	3	4
s. Hopping	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
Column Totals:					

MDC & MCID = 9 points Client adds score Score ____/80

Pre-Treatment Checklist and Consent for Assessment and Treatment

Medical conditions are often the result of many complex factors. Although some of the following questions may seem unrelated to your present problem, they are all associated with proper management of your present condition.

Yes	No	
☐	☐	Heart or Lung condition? (e.g. Angina, PacemakerAsthma, Smoking)______________________
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Stroke
☐	☐	Epilepsy/Seizures
☐	☐	Arthritis (Osteoarthritis, Rheumatoid Arthritis)
☐	☐	Vision or Hearing Loss
☐	☐	SkinDisease______________________________
☐	☐	Back Injury ______________________________
☐	☐	Cancer - type: ______________________________

Do you currently suffer from:

Yes	No	
☐	☐	Shortness of Breath
☐	☐	Chest Pain
☐	☐	Dizziness/Headaches
☐	☐	Infection or Fever
☐	☐	Numbness or Tingling______________________________
☐	☐	Allergy(including creams, medications, latex, tapes)__________________________
☐	☐	Depression

Please answer the following questions and explain if necessary

Yes	No	
☐	☐	Are you currently taking any medications? If so, list ______________________ ______________________________
☐	☐	Have you previously had therapy? ______________________________
☐	☐	Isthis a Worker's Compensation Case? ______________________________
☐	☐	Is this injury due to an accident (e.g. motor vehicle accident, slip and fall etc.) ______________
☐	☐	Are you receiving other treatments at this time? (e.g. Chiropractor, Reflexology, Massage, Other)______________________________
☐	☐	Are there any other conditions which you feel we should be made aware of? (i.e. pregnancy, MRSA, VRE?) ______________________________
☐	☐	Have you had a recent hospitalization? Reason ______________________________
☐	☐	Can we leave a message on a machine or with a person at your contact phone number?

CONSENT FOR ASSESSMENT AND TREATMENT

I authorize the Bluewater Health, Physiotherapy/Occupational Therapy Department to provide me with assessment and treatment.

I have been instructed in the risks and benefits of treatment.

I understand that consent to treatment is an ongoing process, and that I may withdraw my consent at any time.

I understand that a physiotherapy/occupational therapy assistant will be involved in my care.

I understand that I may be discharged from Physiotherapy/Occupational Therapy treatments if I miss 2 scheduled appointments. I will make every effort to notify my therapist 24 hours in advance, if I am unable to attend.

While in Physiotherapy/Occupational Therapy Department I understand that I should not start any exercise, or use any equipment unless I have been instructed to do so.

Signature of Patient/guardian/family member:______________________________

Signature of witness:______________________________ Date: ________________

Bluewater Health

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E-Mail Communications With Patient Agreement

Patient name

NAME IN FULL OF PATIENT OR SUBSTITUTE DECISION MAKER

the ______________________________ of ______________________________

RELATIONSHIP TO PATIENT IF SUBSTITUTE DECISION MAKER — NAME OF PATIENT

have discussed communicating with Bluewater Health via e-mail.

I acknowledge and agree that:

- E-mail is not a secure or confidential form of communication. As the message leaves Bluewater Health, it is sent across the Internet, where it could be intercepted and read. For this reason, Bluewater Health cannot guarantee the security of messages sent to and by me
- My care provider will not use e-mail to communicate sensitive personal or health information
- Specific issues that will **not** be discussed via e-mail include: ______________________________

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- E-mail will **not** be used to communicate emergency or urgent health matters, as I understand that:
- email messages can be delayed for both technical reasons and issues relating to the availability of the health practitioner and
- my condition or the emergency situation cannot be adequately assessed via e-mail
- Clinical decisions about treatment or care may be made on the basis of health information conveyed in e-mail messages
- A printout of any e-mail communication related to treatment or care will be stored in my/the patient's hospital record
- Either party may stop communication via e-mail at any time if the conditions in this agreement are not adhered to. Notice must be given in writing to the patient/SDM or health care provider as applicable, if this form of communication is to stop.

E-mail **may** be used for:

- Conveying routine test results
- Scheduling appointments
- Certain counseling, e.g. nutritional
- Other reasons as agreed upon by myself and my health care provider: ______________________________

Date: ______________________________ ______________________________

(DD/MM/YYYY) — SIGNATURE OF PATIENT OR SUBSTITUTE DECISION MAKER

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PRINTED NAME OF PATIENT OR SUBSTITUTE DECISION MAKER

Date: ______________________________ ______________________________

(DD/MM/YYYY) — SIGNATURE OF HEALTH CARE PROVIDER

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PRINTED NAME OF HEALTH CARE PROVIDER Other