

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)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transfemoral (above the knee)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Partial foot	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Syme's	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ankle disarticulation (through the ankle)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Knee disarticulation (through the knee)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transradial (below the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Partial hand	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Wrist disarticulation (through the wrist)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transhumeral (above the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Elbow disarticulation (through the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hemipelvectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hip disarticulation (through the hip)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rotationplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Forequarter	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Shoulder disarticulation (through the shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (please specify): _____				

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

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: _____
day/month/year

Date: _____
day/month/year

Application Signature

Applicant's signature _____

Date: _____

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day/month/year

