



The War Amps

CHAMP THE CHILD AMPUTEE PROGRAM

2827 Riverside Drive
Ottawa, Ontario K1V 0C4

Telephone: 613 731-3821
Toll Free: 1-800-267-4023

Fax: 613 731-4092
Toll Free Fax: 1-866-235-0350

Email: champ@waramps.ca

CHAMP ENROLMENT FORM

The information requested will assist us in providing resources specific to your child

Child's Name: _____

Child's Address: _____

City: _____ Province: _____ Postal Code: _____

All mail from the CHAMP Program will be mailed to your child at this address only for confidentiality and privacy concerns.

Home Telephone: _____ Email Address (if applicable): _____

Date of Birth: _____ Male _____ Female _____
(day) (month) (year)

TYPE OF AMPUTATION

In order to ensure that our files are as complete and detailed as possible, please provide us with as much information as you can regarding your child's amputation.

UPPER LIMBS	LEFT	RIGHT	LOWER LIMBS	LEFT	RIGHT
Hand	_____	_____	Foot	_____	_____
Partial Hand (describe below)	_____	_____	Partial Foot	_____	_____
Wrist Disarticulation	_____	_____	Ankle Disarticulation	_____	_____
Below Elbow	_____	_____	Below Knee	_____	_____
Elbow Disarticulation	_____	_____	Knee Disarticulation	_____	_____
Above Elbow	_____	_____	Above Knee	_____	_____
Shoulder Disarticulation	_____	_____	Hip Disarticulation	_____	_____

Additional comments or information _____
(use back of page if necessary)

SPECIAL PROCEDURES

Van Nes Rotation _____ Krukenberg _____
Ilizarov _____ Other (provide name and description below) _____

Additional comments or information _____
(use back of page if necessary)

CAUSE OF AMPUTATION

Congenital (Birth Defect)	_____	Medical	_____
Congenital - Surgical	_____	(e.g. cancer, meningococcal, diabetes)	_____
(As a result of congenital defect where surgical amputation has been or will be necessary)		Automobile Accident	_____
Lawnmower Accident	_____	Train Accident	_____
Farm Accident	_____	Electrocution	_____
		Miscellaneous Accident	_____
		(if none of the above)	_____

Additional comments or information _____
(use back of page if necessary)

In order to coordinate financial coverage, please specify if you are receiving assistance from any other agency or if you have an extended health plan through your place of employment.

OPTIONAL: Details of any other medical problems, in addition to those directly related to the amputation, which your child may have such as: cleft palate, internal medical problems, club foot, spina bifida, syndrome (type).

OPTIONAL: Please name the facility or doctor that has referred you to CHAMP:

Doctor: _____

Prosthetic Facility: _____

War Amps Branch: _____

Other: _____

Please indicate Prosthetic Facility/Rehabilitation Centre that you attend:

OPTIONAL: Brothers and Sisters of Child

NAME	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

OPTIONAL: List any languages spoken in the family other than English or French (helpful for our Matching Mothers Program).

OPTIONAL: To complete our information files fully, we would appreciate a recent photograph of your child.



Mother's Name: _____ **Business phone:** (____) _____

Father's Name: _____ **Business phone:** (____) _____

Parent/Guardian Signature: _____

Date: _____
(day) (month) (year)

I would like to receive information in English _____ French _____