

CHAMP Enrolment

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

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

Information About the Child

Child's name: _____
First name Middle name Last name

Date of birth: _____ Gender: _____
day/month/year

Address: _____

City: _____ Province: _____ Postal code: _____

For confidentiality and privacy purposes, all mail from the CHAMP Program will be mailed to your child at this address.

Information About the Parents/Guardians

First parent/guardian: _____
First name Last name

Relationship to child: _____ Lives with child: Yes No Has legal custody: Yes No

Address (if different from child's): _____

City: _____ Province: _____ Postal code: _____

Home phone: _____ Work phone: _____ Ext.: _____ Cellphone: _____

Email: _____

Second parent/guardian: _____
First name Last name

Relationship to child: _____ Lives with child: Yes No Has legal custody: Yes No

Address (if different from child's): _____

City: _____ Province: _____ Postal code: _____

Home phone: _____ Work phone: _____ Ext.: _____ Cellphone: _____

Email: _____

We will require a copy of any custodial agreements in effect. In the absence of information, both parents will have equal access to the child's records.

Vendor Information

Please indicate the person(s) to whom The War Amps reimbursement cheques are to be made payable (i.e., travel expenses for prosthetic appointments, seminars, parades, etc.).

First parent/guardian

Second parent/guardian

Both parents/guardians

Type of Amputation(s)

Upper limbs	Left	Right	Lower limbs	Left	Right
Partial hand	<input type="checkbox"/>	<input type="checkbox"/>	Partial foot	<input type="checkbox"/>	<input type="checkbox"/>
Hand	<input type="checkbox"/>	<input type="checkbox"/>	Foot	<input type="checkbox"/>	<input type="checkbox"/>
Wrist disarticulation	<input type="checkbox"/>	<input type="checkbox"/>	Ankle disarticulation	<input type="checkbox"/>	<input type="checkbox"/>
Below elbow	<input type="checkbox"/>	<input type="checkbox"/>	Below knee	<input type="checkbox"/>	<input type="checkbox"/>
Elbow disarticulation	<input type="checkbox"/>	<input type="checkbox"/>	Knee disarticulation	<input type="checkbox"/>	<input type="checkbox"/>
Above elbow	<input type="checkbox"/>	<input type="checkbox"/>	Above knee	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder disarticulation	<input type="checkbox"/>	<input type="checkbox"/>	Hip disarticulation	<input type="checkbox"/>	<input type="checkbox"/>

The amputation(s) is/are the result of a limb length discrepancy of the: Femur or Tibia/Fibula
 The amputation(s) is/are the result of a limb length discrepancy of the: Humerus or Radius/Ulna
 The limb length discrepancy is: _____ cm or _____ inches

Additional notes: _____

Special Procedures

Rotationplasty Limb lengthening Other Please specify: _____

Cause of Amputation

At birth

Congenital
 Congenital surgical
 (As a result of congenital limb deficiency where surgical amputation has been or will be required)
 Syndrome
 Please specify: _____

Medical

Date of diagnosis: _____
 Cancer
 Meningitis
 Other (e.g., sepsis)
 Please specify: _____

Accident

Date of accident: _____
 Automobile accident
 Electrocution
 Farm accident
 Lawn mower
 Train accident
 Other
 Please specify: _____

Date of amputation surgery (if applicable): _____

Please indicate the prosthetic/rehabilitation centre you attend: _____

Is a prosthetic limb/device currently being made? Yes No

Other Source 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

Please state your language preference: English French

How did you learn about the CHAMP Program? _____

What are your most immediate needs? _____

How do you see CHAMP assisting you and your family? _____

Signature

 First parent/guardian

 Second parent/guardian

Date: _____
 day/month/year

Date: _____
 day/month/year

Please return your completed form to CHAMP.

Charitable Registration No.: 13196 9628 RR0001