



Technology for Independent Living
9007 Shaughnessy Street
Vancouver BC V6P 6R9
www.bcits.org

CLIENT INFORMATION UNDERTAKING

I, _____, hereby authorize the Technology for Independent Living Program and/or its representatives to release to or obtain from such agencies, individuals, medical centres or hospitals as are concerned with my medical rehabilitation, any and all pertinent information which may be necessary to assist in providing me with medical rehabilitation services.

I declare that any financial and other information which I have provided in order for the Technology for Independent Living Program to determine my eligibility to receive service at no cost or at a reduced cost is true to the best of my knowledge and belief.

I understand that all such information will be treated as confidential and privileged, and used only for the purpose of assisting my medical rehabilitation.

I am nineteen years of age or older.

DATED THIS _____ DAY OF _____ 20 _____

SIGNED BY: _____ WITNESS: _____
 CLIENT/REPRESENTATIVE SIGNATURE

STATE RELATIONSHIP TO CLIENT NAME

STREET

CITY /PROVINCE/POSTAL CODE

**"IF CLIENT IS UNABLE TO SIGN, WITNESS:
 A SECOND WITNESS IS REQUIRED"**

SIGNATURE

NAME

STREET

CITY/PROVINCE/POSTAL CODE

CONTACT PERSONS:

(i.e., A person who will assume responsibility for completion of forms, arranging appointments, etc. if client is unable to do this.)

Primary Contact

Name: _____ Relationship to client: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

Alternate Contact

Name: _____ Relationship to client: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

Person Prescribing Equipment

Name: _____ Relationship to client: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

Form Completed by:

Client: Yes No Primary Contact: Yes No Alternate Contact: Yes No

If none of the above:

Name: _____ Relationship to client: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

COMMUNICATION AID REQUESTS

It is recommended that a speech therapist or pathologist be consulted for completion of this application.

An electronic communication system may or may not be a complete solution. **Even when an electronic device is recommended, a non-electronic communication system is an essential component.**

The role of the TIL will be to assist in the assessment, when necessary, and to explore the possible alternatives to meet the needs of the client. This may include modification or adaptation of the system currently in use, or the provision and/or installation of electronic equipment.

Please note: There may be a waiting list for specific equipment and an alternative may have to be substituted. If any changes occur after the completion of this form, please let us know. We look forward to being of service to you.

Please describe present physical condition: _____

Please describe hand function (eg: able to point to 1/2" squares, able to exert pressure with hand/fingers):

If hand/finger function is not reliable, please describe the most consistent, voluntary movement: _____

Please describe vision: _____

Please describe hearing abilities: _____

What does the client use now to communicate with others: _____

Name of speech pathologist or therapist involved with client: _____

Facility/Firm: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

Please attach most recent report/assessment. Date last seen/projected date: _____

Please add any comments which will help clarify your reasons for, and expectations of, this application:

Section completed by: _____ Relationship to client: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

ENVIRONMENTAL CONTROL SYSTEM REQUESTS

An Environmental Control System (ECS) allows a person who is unable to control his/her environment in a usual manner to do so electronically. Devices which are typically operated via an ECS include: lights, radio, television and telephone. A person who can directly access a standard remote control or push button telephone may not qualify for our services.

TIL's Environmental Control Systems are not intended to provide emergency call or home security functions, or to control kitchen appliances or heating facilities.

In many cases, complicated electronic controls may not be needed to enable the user to operate equipment. Our technical staff can advise as to whether the user's own equipment can be adapted, and will adapt it, if appropriate.

A potential candidate for an ECS is any individual who has the desire to maximize independence via personal control over their immediate environment.

An Occupational Therapist or others assisting in this process should be prepared to act as a resource person, who will inform the TIL of any change in status and to be available to assist with the installation and/or follow-up. All system users are asked to be part of an ongoing evaluation and education process.

Our program includes assessment, installation, repairs and follow-up throughout the entire Province. Because of this there may be some delay before we can provide the service you need. If any changes occur after the completion of this form, please let us know. We look forward to being of service to you.

Please describe present physical abilities: _____

Does the person have any hand function? If so, please describe: _____

What equipment can the person operate at present? Please describe the method of operation: _____

Do you have any environmental control devices at present? Yes No

If yes, please describe: _____

What equipment would the person like to operate that cannot be operated at present from a wheelchair/sitting position?

What switch/s have been tried by the person from a wheelchair/sitting position? _____

What switch was most successful? _____

What equipment would the person like to operate that cannot be operated at present from bed/reclined position?

What switch/s have been tried by the person from bed/reclined position? _____

What switch was most successful? _____

Do you have access to person(s) with technical expertise to assist with equipment?: Y N

Name of therapist involved with client: _____

Facility/Firm: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

Please attach most recent report/assessment. Date last seen/projected date: _____

Please add any other relevant information: _____

If you have any questions please call us at 604-326-0175

Please submit this form to us by mail, fax or email:

TECHNOLOGY FOR INDEPENDENT LIVING

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Vancouver BC V6P 6R9

Fax: 604-326-0176

Email: til@bcits.org

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