|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Personal Information** | | | | | |
| Last name: | First name: | | | | Gender: |
| Address: | | | | | |
| Telephone home: | | | | Cell: | |
| Languages spoken:  English  French Other: | | | | | |
| Primary contact for Visiting Buddies purposes:  Client  Caregiver (provide caregiver information on page 2) | | | | | |
| **Availability for visits** | | | | | |
| Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday | | mornings  afternoons  evenings | | | |
| I am not available on the following days/at the following times: | | | | | |
| **Experience & interests** | | | | | |
| Past occupation(s): | | | | | |
| Skills, interests, or hobbies that may be pertinent to the volunteer visitor: | | | | | |
| **Living situation** | | | | | |
| The client lives  Alone  With spouse  With family? | | | | | |
| Is the client widowed?  No  Yes  Notes: | | | | | |
| Does the client smoke?  No  Yes  Notes: | | | | | |
| Is there a pet in the home?  No  Yes  If yes, type of pet: | | | | | |
| **Caregiver information (if applicable)** | | | | | |
| Caregiver first name: | | Caregiver last name: | | | |
| Caregiver phone: | | Caregiver email: | | | |
| **Medical information** | | | | | |
| Limited/compromised mobility  Dementia  Hearing challenges  Speech challenges | | | Incontinence  Impaired vision  None of the above | | |
| Other health concerns: | | | | | |
| Is client on a list for Long Term Care (LTC)?  Yes  No | | | | | |
| Other health services in the home:  Personal Support  Nursing  PT (Physio)  OT (Occupational Therapy)  None  Other: | | | | | |
| Most involved Physician:  Name:  Phone: | | | | | |
| **Emergency contact** | | | | | |
| First name: | | | Last name: | | |
| Relationship to client: | | | | | |
| Main phone: | | | Alternate phone: | | |
| **Other information** | | | | | |
| How did you hear about this program?  Eastern Shore Cooperator advertisement  Poster  Newsletter  Website  Social media  Word of mouth  Other | | | | | |
| **Authorization for collection of Personal Information**  I authorize the Well-Being HUB to collect personal information appropriate to the service/program I am applying for. I understand that the information obtained will be kept confidential. I hereby certify that the above information is true to the best of my knowledge. I agree to keep the Well-Being HUB informed if any of the above information changes at any time. I understand that any willful falsification of information may result in termination of my access to the service being provided. | | | | | |
| **Signature:** | | **Date:** | | | |
| **Thank you for your interest in participating in the**  **Well-Being HUB’s Visiting Buddies Program!** | | | | | |