

**Tool:** **PARTICIPANT SCREENING FIT FOR FUNCTION & TIME™ SAMPLES**

**Section in Planner: Phase 3, Step 7 (7.1)**

**Why is this important?**

Participant screening is an integral component of exercise programs designed for people with stroke. Best practice guidelines1 recommend that a formal screening process be conducted by the exercise provider to ensure a match between the program and the participant and to ensure that the participant meets program eligibility. Screening processes include a range of procedures including individual participant intake interviews, a review of health information from the physician/other referring health care providers as well as a review of functional ability and the need for other considerations.

**How to use this tool:**

Programs may provide recommendations and include a sample waiver in their training materials (e.g. Fit for Function program sample) or a participant questionnaire (e.g. TIME program sample). Municipal recreation facilities often use a standardized form such as the Physical Activity Readiness Questionnaire for Everyone (PAR-Q+)2 and Physical Activity Readiness Medical Examination (ePARmed-X+). The Canadian Society for Exercise Physiology (CSEP) also provides a “Get Active Questionnaire”3 which a participant can use with a fitness health professional to discuss readiness to participate in a program.

**User Comments:**

*“When I was reading Phase 3 and thinking about the medical approval I was, you know, do we just take people’s word for it that they have physician approval to participate? Do we actually get them to sign forms? So, the fact that you included an example of the medical authorization form was perfect because not only did it answer my question, it just gave me something really practical that we could use.”*

(Physiotherapist)

1 Post Stroke Community Based Exercise Guidelines Working Group of the Ontario Stroke Network. Post stroke community based exercise guidelines. 2015 [cited 2020 Apr 10]. Available from: https://www.strokenetworkseo.ca/sites/strokenetworkseo.ca/files/osn-post-stroke-community-based-exercise-guidelines-2016-final.pdf

2 PAR-Q+ Collaboration. 2020 PAR-Q+ The Physical Activity Readiness Questionnaire for Everyone. 2020 [cited 2020 Apr 10]. Available from: http://eparmedx.com/wp-content/uploads/2013/03/January2020PARQPlus\_Image.pdf

 3. Canadian Society for Exercise Physiology (CSEP). Get Active Questionnaire. 2017 [cited 2020 Apr 10].

 Available from: https://www.csep.ca/CMFiles/GAQ\_CSEPPATHReadinessForm\_2pages.pdf

Samples:

YMCA of Hamilton | Burlington | Brantford. Fit for Function - Livewell. 2020 [cited 2020 Apr 10].

Available from: https://www.ymcahbb.ca/Programs/LiveWell/Fit-For-Function-LiveWell

University Health Network. Together in Movement and Exercise (timeTM) program. 2020 [cited 2020 Apr 10].

Available from: https://www.uhn.ca/TorontoRehab/Clinics/TIME

**Participant Screening Form Sample**

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**Healthcare Partner Logo**

**Fit for Function Community Stroke Wellness Program**

**Medical Authorization**

Fit for Function is a program for individuals who have had a stroke. It includes a modified group fitness class two days per week, as well as fitness centre exercise and education one day per week. The program is supervised by a YMCA kinesiologist and a physiotherapist.

|  |  |
| --- | --- |
| Functional exercise classes | Community-Based Exercise Program for Persons Living with Stroke(1 hour, 2x/week)* Warm-up
* Task-Oriented Strengthening and Cardiovascular Training
* Mobility and Balance
* Cool Down
 |
| Independent gym exercise | Supervised drop-in sessions at the fitness centre (1 hour, 1x/week) |
| Education sessions | Weekly sessions based on the Heart and Stroke Foundation’s *Living with Stroke* program |

To refer your patient to this program, please complete the attached Medical Authorization Form.

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**Healthcare Partner Logo**

**Fit for Function Community Stroke Wellness Program**

**Medical Authorization**

|  |  |
| --- | --- |
| Participant’s Name: | DOB: |
| Address: |
| City: | Phone #: |

Please check one and provide details if required:

|  |
| --- |
| * I am not aware of any contraindications or concerns toward participation in this program.
 |
| * The applicant can participate in the program, but I urge caution because:
 |
| * The applicant can participate in the program, but should **not** engage in the following activities:
 |
| * The applicant is not advised to participate in the program because:
 |

This patient has my approval to begin an exercise program with the recommendations or restrictions stated above.

Physician’s signature Date

Physician’s name (print) Phone

Please give this form to your patient, or send by fax to:

(Provide YMCA contact and fax number)

**Participant Screening Form Sample (adapted from TIMETM program)**

*Note: This sample is provided with permission from a Stroke Recovery in Motion study participant. Names of people, organizations, and places have been removed.*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Lower Functional Limit:**

Yes No

□ □ a) Are you currently experiencing balance and mobility limitations resulting from a stroke?

□ □ b) Are you able to walk 10 metres unassisted, with or without a walking aid?

□ □ c) Are you able to balance while exercising in standing with only the support of the back

of a chair?

1. **Upper Functional Limit:**

Yes No

□ □ a) Are you able to walk more than 20-30 minutes without a seated rest?

□ □ b) Are you able to manage environmental barriers (curbs, ramps, and stairs) with relative

ease?

1. **Additional Screening Criteria:**

Yes No

□ □ a) Are you able to access bathroom facilities and perform own personal care

independently?

□ □ b) Are you able to understand and follow directions?

□ □ c) Will you be attending with a caregiver or family member who can assist you, if you are

unable to perform the above?

If participants answer yes to all question 1, no to all question 2, and yes for a & b or c of question 3, then they are appropriate to partake in the TIMETM program once the referral form has been completed by an appropriate health professional.

Participant Appropriate for TIMETM Program: **YES** or **NO**

Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Score on Activities-specific Balance Confidence scale: Pre: \_\_\_\_\_\_\_\_\_\_\_ Post: \_\_\_\_\_\_\_\_\_\_\_

Referral Received: **YES** or **NO**