Métis Nation of Alberta (MNA)
Compassionate Care: Cancer Transportation Pilot Program
Intake Form

Section 1

First Name: _____ Middle Initial: ___ Last Name: _____
Birth Date: _____

Are you a citizen of the Métis Nation of Alberta, or are you willing to begin the application process for citizenship? This is a requirement of participation.
YES: ☐ NO: ☐

Alberta Health Care Number: _____
MNA Citizenship Number: _____

Rider's Address: _____
Pick-up Location (if different than address listed above): _____
Home Phone: _____
Cell Phone: _____
Email Address: _____

Emergency Contact Information
Name: _____
Phone Number: _____
Address: _____
Relation: _____

Section 2

Will you be using the program to get to and from cancer-related appointments? This is a requirement of participation.
YES: ☐ NO: ☐

Do you have your own vehicle with someone to drive you that can be used to drive to your appointments? If yes, skip to Section 4.
YES: ☐ NO: ☐

Will a child be transported?
YES: ☐ NO: ☐

If yes, will you accompany them? Children under the age of 18 are required to have an adult accompany them on all rides.
YES: ☐ NO: ☐

If transporting a child, do you have an appropriate car seat for the volunteer's vehicle?
YES: ☐ NO: ☐

Are you able to independently transfer yourself in and out of the vehicle and in to your appointment?
YES: ☐ NO: ☐

Section 3

Are you required to use a mobility device (walker, wheelchair, etc.)?
YES: ☐ NO: ☐

If yes, do you understand the scheduling of a ride is subject to the availability of a volunteer vehicle that can accommodate these devices?
YES: ☐ NO: ☐

Do you understand that volunteer drivers are not medical professionals and are not qualified to perform any medical procedures beyond basic first aid?
YES: ☐ NO: ☐

Do you understand that rides and/or transportation support is not guaranteed?
YES: ☐ NO: ☐

Please list all allergies (seasonal, food, medications, etc.).
_____
_____

Are you on any medications?
YES: ☐ NO: ☐

If yes, please list all medications, including doses.
_____
_____

Section 4

Do you have any additional medical conditions that the program administrator should be made aware of?
YES (please explain): ☐ NO: ☐
_____
_____

Physician Information
Name: _____
Address: _____
Phone Number: _____

Where will your appointments be located?
Not Sure: ☐

Institution Name: _____
Address: _____
Phone Number: _____
Department: _____
Department Phone Number: _____

Please attach documentation of your appointment.

Section 5

Which family members or friends can drive you at least part of the distance to your appointments?
_____
_____

Do you understand that provision of transportation support does not guarantee you will receive accommodations support through the MNA?
YES: ☐ NO: ☐

What types of appointments will, or do you require?
_____
_____

Please describe how often you will use the program.
Weekly Basis: ☐
Bi-Monthly Basis: ☐
Monthly Basis: ☐
Bi-Yearly Basis: ☐
Yearly Basis: ☐
Unknown: ☐

Please select your yearly household income before tax.
Less than $20,000 ☐
$20,000-$40,000 ☐
$41,000-60,000 ☐
$61,000-$80,000 ☐
$80,000+ ☐

Please provide us with any additional information we may need to serve you better.
_____
_____
_____