



SOADI FOOT CARE Initial Contact Form

Contact Name and Title: _____

Name of Organization: _____

Address: _____

Email _____ Phone _____ Fax _____

Other contact information: _____

Thank you for your interest in hosting a SOADI Foot Care Clinic. We would like to take this opportunity to ask you a few questions that help us keep track of how you heard about the SOADI Foot Care Program and services you may provide or may lack.

How did you learn about the SOADI Foot Care Program?
please circle or fill in blank

Website

Pamphlet/Media

Head Office

Other events

Referral

Regional Diabetes Prevention Coordinator (DPC) Other: please specify _____

Does your organization, program, centre etc have foot care services provided to your community? *Please explain in detail if yes or no (who what where when and how often).*

When was the last foot care service provided to your community: _____

How were these foot care services funded? _____



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SOADI HEAD OFFICE

8 CLAIRMONT ST, UNIT 2, THOROLD, ONTARIO · L2V 1R1
TEL: 905 938 2915, OR 1 888 514 1370 · FAX: 1 866 352 0485

WEB: www.soadi.ca



Who were the service providers for the foot care? *podiatrist, chiropodist, foot care nurse*
please include contact information

Are there any barriers that stop you from having foot care services in your community?
Long waiting lists, no service providers, no funding etc...

What are the foot care needs of your community? Estimated number of people living
with diabetes, estimated number of elderly, estimated number of people in community vs
estimated number of people receiving foot care, etc.

What are the foot care resources given in your community? What do these resources
consist of?

What other programs and or services are provided with your centre, please list.
(Healing and wellness, healthy babies, men's, women's, elders etc.)

***If you have any other questions or need further information please call. Thank
you for your time and assistance.***

Signature/Title : _____ Date: _____



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