Highlife’s “Swimsuit Edition”!

First of all, yes you CAN swim with an ostomy. But should you buy a specialized swimsuit? Not necessarily -- swimsuits for ostomates usually have inner pockets to help hold the bag in place but you may still be able to wear your old suit, or a suit not made specifically for an ostomate just as confidently. ‘Retro’ styles have become fashionable lately which is a boon for ladies who want to wear a two piece but want a higher waistline. Another trend being seen at the beach are covering t-shirts, both long and short-sleeved. This trend towards board “shirts” started in Australia in areas where surfing is popular. Surfers learned it was wise to protect the skin of the upper body from harsh sun and “board rash” (getting smacked by the board). These shirts help conceal an ostomy bag and look cool at the same time.

Two other nice styles for ladies are swim “dresses” and “boy leg” suits. These are longer around the hips and can give you a little more length to help conceal an appliance. (Bonus: they also conceal a droopy butt) Whatever style you choose, the main thing to know is nobody is going to be staring at you. People don’t know you have an ostomy and they really don’t care if you have any lumps or bulges here or there. Most people who don’t have ostomies have lumps and bulges here or there!

Practical Considerations When Swimming

It goes without saying that you need to be fully healed up from your surgery and fit enough to swim if that is what you intend to do. But please be careful; water is cold and your ostomy may be sensitive.

REMAINING 2015 MEETING SCHEDULE:
September 20 (AGM) and speaker Alison McCarlie from Coloplast
Christmas Party December 6 at North Shore Winter Club

CHAPTER MEETINGS ARE HELD ON SUNDAYS AT:
Collingwood Neighbourhood House
5288 Joyce Street
Vancouver at 1:30 PM

NOTE: In the event of severe weather conditions, please call the Collingwood hotline 604-412-3845 to check if the centre is open.
The addition of slim. The advantages of Adapt barrier rings.

The Hollister Adapt barrier ring line of products just got a little bigger and thinner. The newest addition, the Adapt slim barrier ring, delivers the same convenient features of the other Adapt barrier rings—at around half the thickness of the standard 48mm flat ring.

The Adapt slim barrier ring:

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**From Your President**

Our June meeting had another good turnout of 30 people plus ET nurses Lisa Hegler and Andy Manson from Ostomy Care & Supply Centre attended to facilitate another Q & A session. (BTW, did you know that nurses who attend our meetings do so on their day off? Have you hugged your ET lately?) Topics included how to use pouch liners, diet and nutrition, how to stay hydrated, TPN nutrition and a most unusual product from Japan. (This involved nude hot springs bathing and what to do with the bag. OK, you had to be there . . .) We were pleased to surprise member Earl Lesk with an award from Ottawa Ostomy Outreach for the dedication and time he has devoted to supporting overseas ostomates in grave circumstances.

I’m sad to report that we will be losing two steadfast volunteers this fall -- Treasurer Emilia Prychidko and Secretary Donna Savage will be retiring from their positions in September. New member Paul Hunt has kindly offered to stand for Treasurer in the fall which is wonderful news. We will still be looking for a replacement for Donna! Do you have good hearing and can you attend all or most of the four meetings a year? Can you take handwritten notes, type them up at home and email them to me? If you answered “yes” to these, please consider volunteering for position of secretary.

We’re also looking for a backup coffee person! Pierrette Daigle and Stuart MacDougall have been kindly bringing coffee and treats to meetings for over a year now but if they can’t make it we have no back up. Do you have a car and are you able to pick up coffee and tea from Starbucks, Tim Horton’s or whomever you prefer and bring it to our meetings? You will be reimbursed for the cost. Please contact me or Pierrette if you’d like to help out.

Have a healthy and enjoyable summer everyone and I’ll see you in the fall at our AGM September 20. Don’t forget to also mark your calendar for our annual Christmas Buffet December 6 which will change venues this year to the North Shore Winter Club.

**Debra**

PS HEY!! Don’t forget to check out Ostomy Care & Supply Centre’s Customer Appreciation Day August 15!! (see page 8 for details)
LETTERS & NEWS

VCC STUDENT WRITES
Greetings Debra,
Thank you for your wonderful email. I was putting together a presentation for my classmates and the personal accounts that I heard at the meeting were more valuable then any info that I could get from a text book.

The course I am taking at VCC is eight months long and it focuses on helping the elderly and the disabled. Most of the jobs we will be doing apoun graduation will focus on working in home support, hospice, group homes.respite care and extended care facilities. The course covers a wide range of personal care skills as well as medical ascepsis and interpersonal communication . There is a heavy focus on dementia and ends of life care too.

I would definitely like to be on your email list as I have close family with an ostomy and I find the whole subject very interesting . I think people who go through this experience are very brave and my hat goes off to all people who have a stoma. Thanks again for your info and support. I hope you have a great day.

Sincerely,
Kathy John

CENTRE FOR DISEASE CONTROL RESPONDS TO COMPLAINTS ABOUT SMOKING AD NEGATIVELY PORTRAYING OSTOMATES

Dear Ms. Lencina,
Thank you for contacting the Centers for Disease Control and Prevention (CDC) regarding our latest Tips From Former Smokers ad campaign. Please accept our apology for causing you distress with the ads on colorectal cancer. It was never our intent to cause pain to people who have ostomies or to the families and loved ones. We are aware that ostomies are lifesaving procedures and that many people need them for reasons unrelated to smoking.

CDC’s mission is to promote health, and we rely on the support and advice of stakeholders who work on public health issues. In this case, we inadvertently failed to reach out to the ostomy community when we were developing the colorectal cancer ads and missed the opportunity to get their help in encouraging smokers to quit without offending people who are living with ostomies. We recognize and regret any hurt we may have caused.

The 2014 Surgeon General’s report on the health consequences of smoking firmly established a causal link. As you point out, this of course does not mean that a majority of CRC is caused by smoking. But the effect is significant, on all levels. To clarify this, we have changed the wording in the materials from “causes” to “can cause.” “Risk factor” is not a word that is understandable to most smokers, and understates the current level of scientific evidence as summarized in the Surgeon General’s report.

Research tells us that smokers are hardened to information that smoking kills, but they listen and respond to stories about the hardship of living with disease caused by smoking. The Tips campaign was created to encourage smokers to quit. Through these ads, participants share their personal stories of living with the real consequences of smoking. The accounts are graphic, hard hitting, and sometimes difficult to watch, but they have proven to be effective in helping smokers quit. The first cycle of Tips ads in 2012 prompted more than a million and a half smokers to try to quit, and about 100,000 were expected to stay quit for good. That translates to 17,000 people who, because of the 2012 Tips campaign ads, will avoid early death.

The colorectal cancer Tips ads that we are running, like the ads that preceded them, share the stories of people who smoked and as a result are living with the consequences of their smoking-related disease—in this case, colorectal cancer. Both Mark and Julia, the courageous ad participants featured in the Tips colorectal cancer ads, had ostomies and focused on their ostomies as part of their personal stories about smoking-related colorectal cancer.

We have worked very hard on each of the 30 ads produced to try and balance informing smokers about the hardships associated with diseases caused by smoking while avoiding stigmatization of the people with the conditions. We acknowledge that we did not hit the right balance in some of our colorectal cancer material.

Since the colorectal ads began airing in late March, we have learned quite a bit from the response from the ostomy and colorectal communities. Moving forward, CDC will work harder to reach out to both professional and consumer groups related to our public health goals—in this case, the ostomy community. We have sought the advice of the United Ostomy Associations of America, Inc. and are making changes to the ads and their supporting materials. We have changed the ad depicting Julia and Mark as well as Julia’s online story by deleting some of the pointed comments and images specific to ostomies. In addition, we have added messages about ostomies to our Web site.

We very much appreciate you taking the time to give us your feedback on the colorectal cancer ads. Our goal is to learn from the feedback we receive and do better with each initiative we launch to reduce the devastating effects of smoking on our citizens and our country. Your comments will help us get there.

Thank you.

Sincerely,
Office on Smoking and Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention”
Ostomy Solutions for Every Body

We all have different body shapes. We all need individual product solutions and different levels of support. Some short term, some long term.

**Bags and plates**
- **SenSura® Mio Range**
  Ensure a tight, secure fit to individual body shapes and movements.
- **SenSura® Convex Light range**
  Double layer security and skin care combined with a directed pressure to allow the stoma to protrude.

**Accessories**
- **Brava® range**
  Designed to reduce leakage and protect skin. Also helps to achieve customized solutions for different body shapes and needs.

**Coloplast® Care**
A program evolves over time to meet changing needs. Think of it as a personal resource for ostomy wellness education, product samples and dedicated support.

Order free samples today or subscribe for Coloplast Care
1-866-293-6349
Lewis and Clark expedition left a trail of heavy-metal laxatives  

Dozens and dozens of mercury-laden purgative pills invented by Founding Father Benjamin Rush were an indispensable part of the Corps of Discovery’s kit; the toxic-but-effective tablets helped explorers cope with a very low-fiber diet. By Finn J.D. John

As Lewis and Clark’s Corps of Discovery worked its way across North America to Oregon’s Fort Clatsop, it left something behind that would prove invaluable to future historians:

Laxatives.

This sounds trivial today, but at the time laxatives (or, rather, purgatives in general) were a big deal. The Corps left on its journey long before anyone knew what a microbe was, and physicians knew almost nothing about how the human body worked. What they had was a basic theory, which had come down to them from about 150 A.D., courtesy of a Roman doctor named Galen. The idea was that illness was caused by an imbalance in the body’s “humors,” or fluids – blood, phlegm, yellow bile and black bile. Too much blood caused problems like fevers; the answer was to let a pint or two of blood out of the patient. And too much bile caused problems like constipation; the answer was to give the patient a powerful laxative or emetic to cause frenetic purging, from one end or the other.

The wonder drug that works wonders

By the time of the American revolution, a substance called “calomel” was the laxative of choice. Calomel was the wonder drug of the age. In large doses, it functioned as a savage purgative, causing lengthy and productive sessions in the outhouse, guaranteeing the restoration of one’s bile balance. And in small doses, it was effective against the most dreaded “social disease” of the age, syphilis. But take too much of it and your teeth would fall out, and you might die of mercury poisoning. Calomel’s modern scientific name is mercury chloride.

When the Corps of Discovery left the East Coast, Lewis and Clark brought with them several pounds of mercury chloride – in the form of dozens and dozens of beefy white tablets labeled “Dr. Rush’s Bilious Pills.” These pills were almost 50 percent calomel – and they were big pills, at least four times the size of an aspirin tablet.

The pills’ inventor, Dr. Benjamin Rush, was America’s most prominent colonial physician, a signer of the Declaration of Independence and a personal friend of then-President Thomas Jefferson. His star had fallen considerably after the “heroic” style of medicine he favored, featuring heavy purging and copious bloodletting, had a noticeably bad effect on his patients’ survival rate during a yellow fever epidemic in Philadelphia in 1793. But he was still an important man.

“Thunder Clappers”

On the trail, the pills quickly became a critical part of the Corps of Discovery’s kit. More than a few of the men did end up needing treatment for syphilis, either for pre-existing problems or for ones picked up along the way. But almost everyone needed a laxative. Week after week, hunting parties went out and brought back animals to eat. The explorers lived on almost nothing but meat. This low-fiber diet had predictable results. Enter Dr. Rush’s Bilious Pills. The men called these “Thunder Clappers.” They contained Calomel and were extraordinarily effective.

Calomel, as it turns out, is only slightly soluble in human digestion, and much of it goes out with the resulting “purge.” Once in the earth, it lasts virtually forever without dissolving or breaking down. So as Lewis and Clark’s men made their way across the continent and across Oregon, they were unknowingly depositing a trail of heavy metals along the way – a trail that historians and scientists have been able to detect and use to document almost their every movement, so to speak.

A milder version of Rush’s Pills remained an official compound until the 1940s. This “mild” formula was nonetheless a big gun, combining four purgatives of slightly differing qualities: jalap, gamboge, calomel, and colocynth. Early 19th-century physicians regarded jalap as “active” and “rapid.” Gamboge, from Cambodia, was a “drastic” and “powerful” purge. Calomel (mercurous chloride) was believed to stimulate the liver and the gall bladder, although the opposite was true. Colocynth, or bitter apple, from India and Saharan Africa, was termed a “drastic” and “powerful” purge. According to the United States Dispensatory of 1918, the compound extract of colocynth “combined with calomel, extract of jalap, and gamboge, . . . forms a highly efficient and safe cathartic, especially useful in congestion of the portal circle and torpidity of the liver.”

By the 1960s, newer drugs and concerns about heavy metal poisoning led to the disappearance of mercury compounds for internal use. Only a few external mercury-containing antiseptics remained into the 1990s.
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- Draws & Give-Aways
- Meet the Nurses & Staff
do. If you have just changed your appliance, wait an hour before going in the water to make sure it has adhered properly. You should of course empty the bag before going in. Some folks like to tape the flange edges for a little more security; standard “pink tape” will do. Ostomy belts aren’t very comfortable once they’re wet.

**What if People Can See the Bag?**
Here’s something I learned about wearing a bathing suit in public and wondering if anybody can see that I have a colostomy: *NOBODY IS LOOKING AT YOU.* They may give you a cursory glance but unless you’re a) young and cute or b) very handsome or very pretty, nobody is going to be staring at you. Trust me. Almost everybody has lumps and bumps and parts of their bodies about which they are self-conscious. All those other people at the pool or beach may be just as self-conscious as you are about something you don’t even notice! Don’t deny yourself the pleasure of a sport you enjoyed before. Find a suit you like and get out in that water! ✝️

**“Boy Leg” Suit**
*(Speedo Rival)*

**Swim like nobody’s watching!**

**Men’s Board Shorts**
*(Bilabong)*

**A plain T-shirt works for this guy**

---

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NEW PATIENTS’ CORNER

QUESTION OF THE MONTH:
How long should it take to change my pouching system?
Answer: There is no “set time” for this. Everyone works at their own pace and becomes more and more proficient, confident and comfortable as time goes on. In the end, it shouldn’t take more than 15 minutes to complete a change if your stoma is inactive. If you continue to take a long time to change, it may be time to see an ET Nurse to see if your routine can be simplified.

WHAT IS NORMAL OUTPUT FOR A STOMA?

Normal output depends on which type of stoma you have: colostomy, ileostomy or urostomy. Like all output, it can depend on diet, liquid intake etc. For all types of stomas, it is important to drink plenty of fluids, about 6 cups of liquid a day (8 – 10 if you have an ileostomy). This will help keep your output stable and healthy.

Normal output for a Colostomy
The colon usually absorbs water from the waste as it moves along towards the rectum. So, the consistency of output will depend on where your stoma is sited: the further along the colon, the output will be thicker.

The waste passed out from a colostomy is usually fairly firm, so a closed or non-drainable bag is used. The bag is removed and replaced with a new one once or twice a day or as required.

However, if the waste is very liquid (and therefore in greater quantities), some colostomates wear a drainable stoma bag fastened shut at the bottom. The bag can be unfastened and emptied as often as necessary during the day.

If you have just had surgery, it may take a few days for the bowel to start functioning normally again. Passing wind or flatus is the first sign that it is starting to work again. Faeces can be quite fluid in the post-operative period, but should become thicker as your bowel recovers.

It’s important to get into the habit of drinking plenty of fluids and gradually introducing fruit, vegetables and other high fibre foods into your diet. You can still become constipated with a colostomy. If constipation persists, it may be helpful to take a mild laxative. If you have any doubt, ask your doctor or ET nurse. You should also consult your ET nurse if you experience no faeces in the stoma bag, associated with severe pain.

Normal output for an Ileostomy
After bowel surgery, the small intestine gradually adapts and your stoma output should thicken up (to a porridge-like consistency) and reduce to around 400 – 800ml per 24 hours. People with ileostomies wear drainable stoma bags; which are fastened shut at the bottom and can be unfastened and emptied as often as necessary during the day.

Make sure you eat regularly as this helps to regulate stoma function. Occasionally, some people have continuing problems with stool frequency or consistency in which case you may need to take medication to control these issues.

If your output is consistently watery, or if you need to empty the pouch very frequently, you may need tablets to thicken the output, and/or special thickening agents such as Morform which are put in the pouch. If in doubt, ask your ET nurse what he or she would recommend. If the watery output is accompanied by abdominal pain, nausea or vomiting you should seek medical attention straight away.

Normal output for a Urostomy
When you first have your stoma surgery, the urine draining out of your stoma will be bloodstained. It will gradually clear, but can remain discoloured for 2 – 3 weeks.

You will need to empty your urostomy bag via the outlet tap several times a day, as urine flows from the urostomy continuously. To avoid getting up in the night to empty your bag, you may need to add on extra capacity by means of a night bag. This is attached via a long tube to the tap at the bottom of your usual bag. You can either place the night bag on a stand or hang it out of the end of the bed resting in a bowl or bucket. The night bag should be cleansed daily and changed every week. Some people prefer to use a leg pouch at night (and some also do this in the day).

It is usual to expect mucus in your urostomy bag, as your stoma is made from a piece of bowel. The amount should decrease over time but may be helped by taking Vitamin C or a daily glass of cranberry juice. (Warning: if you take Warfarin you should not drink cranberry juice.) You may experience either diarrhea or constipation in the first few weeks after your operation; if so, speak to your GP.

- Halton Peel Newsletter, May 2015; http://www.clinimed.co.uk/Stoma-Care/FAQs/What-is-the-normal-output-for-a-stoma.aspx

10 Vancouver Ostomy HighLife - July / August 2015
CONTROLLING GAS
In other words, farting. Everybody expels gas but now yours will exit from the front of your body and unlike those with an intact set of bowels, you can’t hold it in. This can cause some embarrassment in public if the noise is audible or if there is an odour, and it can sometimes cause problems overnight if the bag gets too full of gas that isn’t being vented. Most bags have a filter, which will help with letting the gas out, but filter effectiveness can be minimal at times. A pouch that is strained by an overabundance of gas may be at risk of breaking the seal and leaking.

OVERNIGHT
It’s important to watch what you eat prior to bedtime. Be cautious about beans, broccoli, starchy breads and pastas, and especially soft drinks. All of these can cause gas buildup and could potentially cause an issue for you overnight. Also, try to refrain from eating too close to bedtime; a suggested deadline is 1 1/2 hours before bedtime. If you need a small snack at bedtime, try to avoid the above problematic foods. Be sure to empty or ‘burp’ the bag before turning in.

IN PUBLIC
Again, do your best to avoid the most gas-producing foods if you can. You can help limit gas production by:
• eating slowly
• have loose dentures refitted
• avoid milk products if you are lactose intolerant
• avoid using a straw to drink liquids
• limit eating foods that contain sorbitol and fructose
• limit carbonated beverages

Despite your best efforts to discourage gas production, your guts will always expel some gas. For new ostomy patients, this can be a huge source of worry because they dread being embarrassed. It’s normal to feel that way and we all felt self-conscious in the beginning. You’re going to be hyper-sensitive to your own body sounds for a while so bear in mind that what sounds loud to you may not be audible to others. Your body may give you subtle signs a moment or two before expelling gas and you will become tuned in to this, giving you time to employ a few tricks to mask the sound. A well-time cough can help, or rustling papers or shopping bags. You can hold something like a parcel or purse over your stoma to muffle sound, or even your forearm casually crossed and pressed over top can help suppress things. If you’re in a crowd you can play innocent but if there’s no way out a simple “Excuse me” will do. Nobody’s perfect. Everybody on the planet has accidentally farted in public.

Regarding gas odour control, eating yogurt or buttermilk helps some individuals reduce odour. Parsley is another natural deodorizer. For something stronger, try Devrom tablets. (available at your ostomy supply store) You chew one to three of these after a meal or snack and they can be pretty effective in neutralizing scent. The taste is mildly pleasing, sort of like banana. Devrom will turn your stool black but this is harmless.

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CRA. The ruling comes back usually within eight weeks.

The completed form (Parts A and B) is then sent off to the CRA. The ruling comes back usually within eight weeks.

Claimants must fill out Part A of Form T2201 and then ask their medical practitioner to fill out and certify Part B, which spells out the specific medical impairment. It is the eight pages in Part B that can pose problems (more about that later).

You don’t need to be wheelchair-bound or severely disabled to qualify for the disability tax credit. The non-refundable credit takes in a broad range of mental and physical impairments. And then there are the fees that dozens of third-party consultants charge to help people claim the tax credit.

The CRA’s own estimates show that at least 1.1 million Canadians are eligible for the credit, half of them seniors. But only 620,000 claimed it in 2012-13, saving themselves a total of almost $1 billion in federal tax. A federal consultation late last year heard from hundreds of disabled people and other interest groups with ideas on how to improve the tax credit. Could the application process be made easier? Are the rules around who can claim it too restrictive? Should there be a cap or limit on the fees that some clients have paid to access the money they’re owed?

The ABC’s of the DTC
The basic disability tax credit is an attempt to address, through the tax system, the added costs of living with an ongoing disability. People who qualify get tax relief that amounts to as much as $1,165 a year, with a supplemental benefit for those under 18 that’s worth up to $680 a year. Provincial credits provide even more tax savings.

The requirements to be eligible for the disabled tax credit are laid out in the T-2201 DTC certificate application form. Among other things, there must be a prolonged impairment in physical or mental functions that must have lasted, or be expected to last, for a continuous period of at least 12 months. But the DTC is unlike other tax credits in that it can’t be claimed until the application has been approved. Claimants must fill out Part A of Form T2201 and then ask their medical practitioner to fill out and certify Part B, which spells out the specific medical impairment. It is the eight pages in Part B that can pose problems (more about that later).

The completed form (Parts A and B) is then sent off to the CRA. The ruling comes back usually within eight weeks.

CRA figures show that, in recent years, about 90 per cent of the claims have been approved. Once approved, claimants can ask for a reassessment to claim disability tax credits going back up to 10 calendar years, depending on when they would have become eligible for the credit. Add up the federal and provincial credits, multiply by 10, and you quickly realize that there’s a potential for a tax refund in the tens of thousands of dollars.

‘Predatory practices’
A number of private-sector consultants have cropped up who will handle all the work for fees that the CRA says can take as much as 40 per cent of the refund.

Enter “disability tax credit consultants” into a search engine, and you’ll be presented with a long list of firms that trumpet their success in getting refunds of $20,000, $30,000, even $40,000 for clients — for a fee. While the consultants insist they provide a much-needed service, a few of them have been accused of being too aggressive.

The whole idea of disabled people — many of whom live below the poverty line — giving up a third or more of their tax refund does rankle. So, it is these tax credit consultants — the government calls them promoters — who are the focus of 2014’s bluntly named Disability Tax Credit Promoters Restrictions Act. Cheryl Gallant, the Conservative MP who introduced the legislation, told the House of Commons that it was designed to “better protect disabled Canadians from the predatory practices of some disability tax credit promoters.” The act, which sets up a regulatory framework in what has been an unregulated industry, has now been passed. All that remains is for Ottawa to determine what limits should be placed on those fees.

The consultants
The Association of Canadian Disability Benefit Professionals, which represents 12 firms that perform these types of services, says its members play by the rules and all cap their contingency fees at 30 per cent. If they don’t win a refund claim, the client pays nothing other than a nominal application fee.

Fee options the government is considering:
• Fixed maximum dollar amount.
• Base dollar amount, plus an extra amount for each tax year amended. The extra amount could be a set dollar amount or a percentage of the refund.
• A graduated amount based on the size of the refund — a fixed percentage for the first part of the refund and a reduced fixed percentage for any amount over that first part.

A Winnipeg-based tax credit consultant says it isn’t just
potential claimants, but also their doctors, who frequently don’t understand that severe disabilities are not the only ones that qualify for the DTC. The result, according to Barry Ho of BMD Services, is that doctors will often tell patients they don’t qualify when, in fact, they do. Ho says he knows of doctors who have told patients they couldn’t qualify for the DTC simply because they walked into the examining room and thus were assumed to be too mobile to qualify.

“The key aspect of the DTC is for anyone involved to understand that the DTC qualifying rules include the severe, moderate and less-than-moderate restriction levels,” Ho said. “Doctors, for the most part, do not understand how to complete the DTC certificate for the moderate and less-than-moderate groups.” Ho, who is a former CRA auditor, says it would be more accurate to rename the disabled tax credit as “the health restriction tax credit.”

He defends his fee — 22 per cent — as appropriate for the level of work involved and says tax credit consultants provide “a key and needed service.”

‘Last resort’

But charities and many other support groups counter that no one should be paying thousands of dollars to access their DTC refunds, no matter how complicated their cases.

“We’re totally against these companies that are charging on a commission basis of 30 per cent or 40 per cent,” said Neil Pierce, national vice-president of government relations for the Multiple Sclerosis Society of Canada. “We help people with appeals if they get an adverse decision [from the CRA],” Pierce told CBC News. “I don’t see why, even supporting an appeal, you would pay such high commissions.”

Where else can you go if you don’t want to do the paperwork yourself?

“If people are uncomfortable with completing the process [of filing for the DTC] themselves, they could utilize the services of a qualified accountant and pay a few hundred dollars in fees,” says Graeme Treeby, the founder of the Stouffville, Ont.-based Special Needs Planning Group, an organization of parents of individuals with disabilities.

Treeby, a former accountant who has written a step-by-step guide on how to claim the DTC, calls contingency fee consultants an “absolute last resort.”

The CRA has simplified the DTC claim form over the years. But disability advocates say the claims process can still pose some hurdles.

“It becomes more challenging for people with disabilities to do appeals of denials,” says Laurie Beachell, national co-ordinator of the Council of Canadians with Disabilities. “We don’t think the private sector should be benefiting from long-term, restorative payments around the DTC. But we do acknowledge that some people need help.”
Diverticular Disease This month we had a request to discuss diverticular disease and whether there were any advantages or disadvantages to performing colostomy irrigations with this diagnosis.

Diverticular disease affects the colon or large intestine of individuals who are typically over the age of forty. The intestine is made up of four layers. The innermost layer is mucosa which has billions of tiny finger-like projections that absorb water and nutrients from the digesting food. The next layer is the sub-mucosa, which carries the blood vessels. The third layer is muscle—there are actually two different muscle layers working together to provide strength and motility. And finally, the entire bowel is encased in a serosa layer, which is a thin, fibrous layer that lines the entire abdominal cavity, including the bowels.

Diverticular disease is characterized by pouches or sacks bulging out from the wall of the intestine. These sacks are called diverticula. If you were to look at the intestine from the inside, you would see small holes along the walls, but the outside of the intestine is where the marble-sized pouches are seen, often appearing like clusters of grapes. The exact cause of diverticular disease is unknown, but is thought to be related to weakened areas along the bowel wall. These areas “herniate” when the pressure within the bowel increases, such as with constipation or straining to have a bowel movement. There are two categories of diverticular disease. The first is diverticulosis. This is when the person has pouches or sacks (diverticula) bulging from their intestine, but have no symptoms. This would explain why 75% of individuals who have diverticular disease, don’t know it. The second, diverticulitis, happens when the pouches become inflamed or infected. This is caused by the opening of the diverticula becoming blocked with stool. Stool is full of bacteria to help with digestion. But when this bacteria becomes trapped in one of the diverticula, it multiplies, causing inflammation and infection. The longer the stool plugs the opening, the harder and drier it becomes, making it more difficult to dislodge. Symptoms of diverticulitis are pain in the lower left side of the abdomen, diarrhea alternating with constipation, nausea, vomiting, fever, chills, cramping and bloating.

One quarter of all people with diverticulitis will develop further complications. These include bowel obstructions due to scar tissue, fistula (where a tract forms from the inflamed pouch to the bladder, another portion of the bowel, or outside of the body), abscess or peritonitis (when a pouch ruptures spilling stool into the abdomen, commonly called a perforation).

To manage diverticular disease, it is recommended that the individual eat a high fiber diet and drink approximately 2 liters of non-caffeinated, non-alcoholic fluids per day. During a diverticulitis flare-up it is best to eat bland, low fiber diet until the symptoms have eased. This means avoiding fruit and vegetable skins, nuts and seeds, whole grain products, beans, lentils, legumes, raw fruits and vegetables and dried fruits. As the symptoms subside, you can gradually reintroduce the high fiber foods back into your diet.

For uncomplicated diverticular disease, there are no contraindications for colostomy irrigations. In layman’s terms, this means that if you don’t have a fistula, are not currently experiencing an obstruction and have no active abscesses/infections, you can perform colostomy irrigations without any worries. I was unable to find any evidence indicating that irrigations may benefit diverticular disease specifically by preventing flare ups. I did find an article discussing the benefits of irrigating blocked diverticula during a scoping procedure. This article described how the physician performing the scope would direct a stream of water to dislodge the stool blocking the opening to the diverticula. They speculated that this may decrease flare-ups. In contrast, a colostomy irrigation involves a gentle gravity infusion which would likely not dislodge impacted feces. However, at the very least, irrigations would ensure regular bowel movements. Regular bowel movements mean no constipation and softer stools. This would decrease the strain on the bowel and possibly prevent more diverticula from forming.

Tips & Tricks

- When flushing a night drainage bag, add a teaspoon of ordinary vinegar to the water for a cheap and effective cleaner. If you can’t find a small enough funnel for this, use the pouch itself. First push your finger through the non-return valve inside the pouch for the water to flow freely -- the pouch then becomes the funnel.

- If you notice a persistent odour after changing your appliance, check to see if you have cleaned the tail piece properly. It isn’t necessary to clean the inside of an appliance (as it is acting like the inside of your colon), but the end of the tail flap is exposed to the outside and will cause odour if fecal material is not removed. A careful swipe with a piece of tissue will do the trick.

- If you are eating dried fruit in an effort to increase fibre intake, be aware that dried fruit absorbs water in your body, which can add to dehydration.

The Vancouver Chapter extends a warm welcome to new members

Arvilla Read
Fran Wong
Deborah Haughton
Cecil Rempel
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**SUN SMARTS**

Sunscreens help shield you from the sun’s dangerous ultraviolet (UV) rays in two ways. Some work by scattering the light, reflecting it away from your body. Others absorb the UV rays before they reach your skin.

A few years ago, choosing a good sunscreen meant you just looked for a high sun protection factor (SPF) — which rates how well the sunscreen protects against one type of cancer-causing UV ray, ultraviolet B (UVB). “SPF refers to blockage of UVB rays only,” says Leffell.

Research soon showed that ultraviolet A rays (UVA) also increase skin cancer risk. While UVA rays don’t cause sunburn, they penetrate deeply into skin and cause wrinkles. The Environmental Protection Agency estimates that up to 90% of skin changes associated with aging are really caused by a lifetime’s exposure to UVA rays.

**Broad-Spectrum Sunscreens**

So which is the best sunscreen for you? Clearly, you’ll want a sunscreen with broad-spectrum or multispectrum protection for both UVB and UVA. Ingredients with broad-spectrum protection include benzophenones (oxybenzone), cinnamates (octylmethyl cinnamate and cinoxate), sulisobenzone, salicylates, titanium dioxide, zinc oxide, avobenzone (Parsol 1789) and ecamsule (Mexoryl SX).

**SPF 15 or higher for UVB protection.** The SPF factor rates how effective the sunscreen is in preventing sunburn caused by UVB rays. If you’d normally burn in 10 minutes, SPF 15 multiplies that by a factor of 15, meaning you could go 150 minutes before burning. For the vast majority of people, SPF 15 is fine, Leffell tells WebMD. But people who have very fair skin, a family history of skin cancer, or conditions like lupus that increase sensitivity to sunlight should consider SPF 30 or higher. Keep in mind that the higher the SPF, the smaller the increased benefit: contrary to what you might think, SPF 30 isn’t twice as strong as SPF 15. While SPF 15 filters out 93% of UVB, SPF 30 filters out 97%, only a slight improvement.

**UVA protection.** There is no rating to tell you how good a sunscreen is at blocking UVA rays, says Leffell. So when it comes to UVA protection, you need to pay attention to the ingredients. Look for a sunscreen that contains at least one of the following, Leffell says: ecamsule, avobenzone, oxybenzone, titanium dioxide, sulisobenzone, or zinc oxide. Any of those should do the trick. Some of the claims about the more expensive products are advertising hype, says Leffell. For instance, any brand-name sunscreen that has avobenzone is stabilized. If you want to spend $30 on a bottle of sunscreen, go ahead. But you can get equally good protection for a lot less.

**Water and sweat resistance.** If you’re going to be exercising or in the water, it’s worth getting a sunscreen resistant to water and sweat. But understand what this really means. The FDA defines water resistant sunscreen as meaning that the SPF level stays effective after 40 minutes in the water. Very water resistant means it holds after 80 minutes of swimming. These sunscreens are in no way waterproof, so you’ll need to reapply them regularly if you’re taking a dip.

**How to Wear Sunscreen**

While choosing the right sunscreen is important, it won’t help much if you don’t use it daily and correctly. Use these tips from the experts.

The Guidebooks are available for download in PDF format from Bladder Cancer Canada’s website in both English and French. You’ll need to have Adobe Acrobat Reader, available for free online.

These new Patient Guidebooks offer valuable information and tips to help you understand your treatment for bladder cancer after diagnosis. Two versions are available - one for patients with nonmuscle-invasive bladder cancer and one for patients facing radical cystectomy.

New Guidebooks From Bladder Cancer Canada

These books are written by people just like you – bladder cancer patients and their caregivers. Each medically-reviewed Guidebook offers useful information to help you understand the patient experience after a diagnosis of bladder cancer. They’re written in plain, easy-to-understand language to increase your comfort level and help you make sense of the procedures ahead. The Guidebooks cover the two, major bladder cancer treatment approaches:

For patients with nonmuscle-invasive bladder cancer

For patients facing radical cystectomy
Your Independence, Our Solutions

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- Ileostomy
- Urostomy

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FRASER VALLEY OSTOMATES HOLD FIRST MEETING

The Fraser Valley Ostomates enjoyed a successful and fun first meeting on the evening of Thursday, June 11. With an attendance of about 25 people, we were enthralled with Julie Singer’s (Inside Wellness) inspiring presentation on her life adventures while living with an ostomy. Group members also enjoyed socializing and grabbing a snack together. Plans are underway to hold regular quarterly meetings in order to provide support and a social network for ostomates living in the Fraser Valley. Stay tuned for future announcements! Many thanks to Nightingale Medical for providing space and resources; and the Vancouver UOA for their guidance and support. Inquiries and suggestions are gladly received by Laura Mercer at lauramercer59@yahoo.com.

Questions or Concerns About Your Diet or Medications? Call 811 for free consultation!

Thanks to the following folks who have donated to kindly to the chapter and/or Youth Camp:

- Deborah Haughton
- Arvilla Read
- Cecil Rempel
- Murray Doull
  in memory of Claire Doull

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Julie Singer (Inside Wellness) presents “Choose Your Own Adventure . . . Ostomy Included!” - photo Laura Mercer


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Lisa

- Also: Susan A
- Susan H
- Christina
- Andy
- Lucy

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Web: ostomycareandsupply.com
**SUN SMARTS cont from page 16**

- Apply the sunscreen 15 to 30 minutes before you go out in the sun. For woman, sunscreen can be applied under makeup. Use about 1 ounce (or 2 tablespoons) to cover your whole body. Don’t skimp. A number of studies show that people simply don’t use enough -- and only get 10% to 25% of the benefit.

- Don’t forget the easy-to-miss spots, like the tips of your ears, your feet, the back of your legs, and, if you have one, your bald spot. Since your lips can also get sunburned, use a UV-protective lip balm and reapply it regularly, Fairbrother says.

- No matter how long-lasting it’s supposed to be, reapply sunscreen at least every 2 hours, and more often if you’re sweating or getting wet.

- Pay attention to the expiration date on the bottle. Sunscreen loses its effectiveness over time.

- Wear sunscreen whenever you’re out during the day -- and not only when it’s hot and sunny. On a grey, overcast day, up to 80% of the dangerous UV rays still make it through the clouds. And during the winter, exposure to the sun’s rays still can have damaging effects on your skin.

**Sunscreen Isn’t Enough**

Some people have the impression that wearing sunscreen makes them fully protected against the sun’s rays, Lim tells WebMD. But that’s not the case. No sunscreen can do that.

No matter how high the SPF, no matter how thickly you slather it on, sunscreen will never fully protect you, experts say. This misunderstanding can be dangerous: people who think they’re safe wind up spending too much time in the sun and raise their risk of skin cancer and other problems.

Even your clothes may not protect you. The average cotton T-shirt only has a pitiful SPF of 4, says Leffell.

So in addition to wearing good sunscreen, you still need to take other precautions:

- Stay in the shade when possible.
- Wear sunglasses.
- Stay inside when UV radiation levels are highest, usually from 10 a.m. to 4 p.m. in the U.S.
- Wear a broad-brimmed hat.
- Wear sun-protective clothing, preferably with a UVP (ultraviolet protection rating) on the label. At least wear clothes that are dark and tightly woven, which offer a bit more protection.

Sunscreen works, says Leffell. But protecting yourself against ultraviolet rays requires a lot more than sunscreen alone. And remember that with sunscreen, you need to defend yourself against the sun’s rays with both UVA and UVB protection.

- From WebMD, By R. Morgan Griffin; Reviewed by Brunilda Nazario, MD
Seeking Surgically Altered Colorectal Cancer Survivors for “I Am” Photographic Series

Kendra Brown and Cynthia Haynes are seeking those who have survived colorectal cancer for a unique and impressionable “I Am” photographic series, whether you have an ostomy or surgical scarring that shows your success as a cancer warrior. The series aims to empower individuals to embrace beauty and strength through acceptance and celebration of their own body.

Powerful, beautiful and vulnerable are some of the words used to describe Cynthia’s unique take for those who have participated in this project. This initiative inspires to raise awareness of colorectal cancer survivors and fundraise for the Peritoneal Malignancy fund, which will support the advancement of treatment of peritoneal cancers at Vancouver Acute.

Kendra Brown, an ostomate, has been diagnosed with three cancers throughout her life. In an effort to see improvements to treatment and identification of cancers, she has started numerous fundraising projects, with “I Am” being one of the latest, benefitting the VGH and UBC Hospital Foundation.

Cynthia Haynes, photographer for “I Am”, is a survivor of Stage 3 breast cancer with a double mastectomy. One of her goals during photoshoots is to capture raw and honest moments with her participants.

To participate in the “I Am” photographic series, please contact Cynthia or Kendra at:

cynthia@cynthia-haynes.com
brokendra@gmail.com

Over or under? The toilet paper debate answered by 1891 patent  Eun Kyung Kim TODAY

The debate is so over.

The age-old argument about whether toilet paper should go “over or under” has been settled by an 1891 patent unearthed by one writer.

And it’s over. Tech writer Owen Williams tweeted the original patent owned by Seth Wheeler, who “invented certain new and useful improvements in toilet-paper rolls.”

For some reason, the inventor seems to make a big fuss about the fact that he came up with the idea of inserting perforations into the roll. But for TP users more than a century later, the takeaway is this: The drawing Wheeler submitted with the patent application clearly shows how rolls should hang.

Once and for all, folks, it’s over.

Now let’s focus on that other household debate: leaving the toilet seat up or down.

Tips & Tricks

• You can apply your pouch standing, lying or sitting; but do not allow abdominal wrinkling or this will break the seal when you straighten up.
• if you have a urostomy and use a night drainage system -- avoid air pockets by connecting the night bag to a half full body pouch and squeeze the urine through the night bag. The body pouch will then remain empty overnight.
• Buttermilk will soothe an irritated digestive tract and will not cause diarrhea or constipation.
HOSPITALS WITH ET NURSES - LOWER MAINLAND
Not all hospitals offer out-patient clinics - call for information

<table>
<thead>
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<th>Hospital Name</th>
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<tr>
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<td>Abbotsford</td>
<td>Tel (604) 851-4700 Ext 642213</td>
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<tr>
<td>Burnaby General Hospital</td>
<td>Burnaby General Hospital</td>
<td>Tel (604) 421-6174</td>
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<td>Children's Hospital</td>
<td>Vancouver</td>
<td>Tel (604) 875-2345 Local 7658</td>
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<td>Port Moody</td>
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<td>Richmond General Hospital</td>
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<td>Tel 604-244-5235</td>
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<td>Vancouver</td>
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</tr>
<tr>
<td>Surrey Memorial Hospital</td>
<td>Surrey</td>
<td>Tel (604) 588-3328</td>
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OSTOMY OUT-PATIENT CLINICS
Post-surgical follow up and consultation

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<tr>
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<td>2188 West Broadway</td>
<td>Tel: 604-738-0733</td>
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<tr>
<td>Nightingale Medical Supplies</td>
<td>Vancouver (Kitsilano)</td>
<td>Tel 604-879-9101</td>
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<tr>
<td>Nightingale Medical Supplies (4 Locations)</td>
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<td>Tel 604-879-9101</td>
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<td>Langley</td>
<td>Tel 604-427-1988</td>
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<tr>
<td>Nightingale Medical Supplies</td>
<td>White Rock</td>
<td>Tel 604-536-4061</td>
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All locations have scheduled clinic availability. Appointments can be booked by calling the stores directly.

VISITOR REPORT
Visits for this reporting period were:

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<td>Other</td>
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TOTAL 7

Thanks to the volunteers: Patsy Peters, Elaine Green, Diana Mercer, Shabita Teja and Julie Singer
MEMBERSHIP APPLICATION

United Ostomy Association Vancouver Chapter
Membership is open to all persons interested in ostomy rehabilitation and welfare. The following information is kept strictly confidential.

Please enroll me as a ___ new ___ renewal member of the United Ostomy Association Vancouver Chapter.
I am enclosing my annual membership dues of $30.00. I wish to make an additional contribution of $__________, to support the programs and activities of the Vancouver Chapter and the national Ostomy Canada Society. Vancouver Chapter members receive the Vancouver Ostomy Highlife newsletter, become members of Ostomy Canada Society and receive the Ostomy Canada magazine.

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City __________________________________ Postal Code _________________ Year of Birth ________
email (if applicable): _____________________________________________________________________

Type of surgery: _____ Colostomy _____Urostomy _____ Ileostomy ____ Internal Pouch _____ N/A

May we welcome you by name in our newsletter? ____ OK ____ I’d rather not

Additional contributions of $20 or more are tax deductible. Please make cheque payable to the UOA Vancouver Chapter and mail to: Membership Coordinator, 3443 Dartmoor Place, Vancouver BC V5S 4G1