Region of Waterloo
COMMUNITY SERVICES

Community Housing Access Centre (CHAC)
235 King Street East, 6th Floor, Kitchener, ON N2G 4N5
Phone: (519) 575-4400 Fax: (519) 893-8648
CHAC E-Mail (chac@regionofwaterloo.ca)
CHAC Website (www.regionofwaterloo.ca/chac)

Medical Form

Patients Name:_____Date of Birth:_____

Release by Patient: I hereby authorize my physician to release and clarify the following medical information to the Region of Waterloo's Community Housing Access Centre (CHAC) and I understand that such information is **confidentially** retained in my file.

Patient's Signature:_____Date:_____

Important Note to the Physician

Your patient has applied for housing and this form requires completion for one of the following reasons: to verify your patient's ability to live independently; to identify what supports are required to enable your patient to live independently; or to verify their need for a modified/wheelchair accessible unit. The information that you provide will allow CHAC to determine whether our housing program can accommodate your patient's needs.

Please type and/or print your report

1. Type of Disability/Medical problems (indicate all that apply):
   Psychiatric: Yes____No____Developmental: Yes____No____Physical: Yes____No____

2. Specific health Problem(s) (If patient is terminally ill, specify both the diagnosis and life expectancy):

   _____

   _____

   _____

3. Are your patient's health problem(s) aggravated by their current accommodations?
   Yes____No____
   What specific elements of the patient's current housing are exacerbating their health:

   _____

   _____

   _____

4. As a result of the above health problem(s), is your patient totally and permanently disabled, and of such a nature that functional ability can be improved by more suitable housing conditions?

   Yes____No____

   If yes, explanation must be provided stating what conditions would be required:

   _____

   _____

   _____

5. How do you think your patient's medical status will be affected by being housed in a subsidized unit?

   Improve_____Deteriorate_____No Change_____Not Predictable_____

   _____

   _____

6. Treatment and medication required:

   _____

   _____

7. Does your patient use a wheelchair? Yes_____No_____

   If yes, please specify: Full time____Occasionally____

8. Does your patient have any special housing requirements (i.e. barrier free building, grab bars, unable to do stairs, needs elevator, etc.)? Yes___No_____

   If yes, please explain:

   _____

   _____

9. Keeping in mind that your patient is applying for independent living with no support staff to monitor your patient's health/physical/emotional requirements **or** provide assistance with basic daily functions such as cooking, cleaning, bathing, shopping, etc. - in your medical opinion is your patient able to live independently? Yes_____Yes, with assistance_____No_____

   If yes, with assistance, please identify what assistance is required and who will provide same:

   _____

   _____

Please provide any additional information that might be helpful:

_____

_____

_____

Physician's Release

I hereby certify that this information represents my best professional judgement and is true and correct to the best of my knowledge.

Physician's Stamp Here:

Physician's Name (printed):_____

Physician's Signature:_____

Date:_____ Phone Number:_____