Region of Waterloo
COMMUNITY SERVICES

File #_____

COMMUNITY HOUSING ACCESS CENTRE

235 King Street East, 6th Floor, Kitchener, ON N2G 4N5
Phone: 519-575-4400 Fax: 519-893-8648
E-mail: chac@region.waterloo.on.ca
Website: www.regionofwaterloo.ca/chac

MEDICAL FORM

Patient's 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 Name Birth 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: (please check correct one).

☐ Psychiatric ☐ Developmental ☐ Physical

2. Specific Health Problem(s): Please note, 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? What specific elements of the patient's current housing are exacerbating their health?

Yes ☐

No ☐

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.? If yes, please explain:

_____

_____

_____

_____

_____

_____

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_____

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

_____

_____

_____

_____

10. 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 Name (printed)_____Telephone _____

Physician's Stamp Here