ACCESSIBILITY MEDICAL QUESTIONNAIRE

To be considered for the waitlist for an accessible and/or modified housing unit, Dufferin County Housing requires supporting medical documentation. This information is necessary to:

- Approve or deny your request for accommodation, and
- Ensure that all your medical accommodation needs are appropriately met.

Please ensure that all relevant medical documentation is submitted with your application to avoid delays in processing.

The following medical questionnaire is the document that will assist in determining two things: 1) if your request is based on your medical needs and 2) what your medical needs are to be safe and functional in your home.

This document must be completed by your **licensed health care professional.**

Once it is completed, please submit it to Housing Access Dufferin at the address below or **had@dufferincounty.ca.** It is recommended that you make a copy for your own records.

This document is your official request for medically required accessibility accommodation. You will be contacted in writing advising of your approval status within 30 days of the request. Completing and submitting this form does not guarantee your request will be approved.

If you are a currently on the HAD waitlist with an eligible status who requires an accessible unit, unit modifications, or other accommodation based on a *Human Rights Code* identified need, please have a qualified medical practitioner who is licensed to practice in Canada complete this form.

If you need this information in an alternative format or another language, please contact the office at 519-941-6991 ext 2021.

Accommodation/Accessibility Request

Important notes to licensed healthcare professionals and their patients:

- The use of a **scooter** or **walker** does not necessarily qualify a patient for a modified/accessible unit.
- **Modified units** provide varying degrees of modification and accessibility depending on individual need.

Patient Information

To be completed by a qualified medical practitioner who is licensed to practice in Canada:

1.	**Patient details:** First name: _____ Last name: _____ Address: _____ Unit #: _____ Date of birth (mm/dd/yy): _____ Parent/Guardian's name (if patient under 18): _____		
2.	How many years has this patient been under your care?		
3.	You understand and agree that you are providing your own qualified medical opinion with respect to the facts stated in this form and you understand and agree that when this form refers to a "medical reaction", the reaction referred to is one that is outside the range of how an average person would react. ☐ Yes ☐ No		
4.	Please provide your medical opinion with respect to the patient's functional abilities that are relevant and apply. Include additional details in section 6. If the ability is not relevant to the request, place a diagonal line through the text box.		
a.	**Walking** ☐ Full abilities ☐ Up to 100 metres ☐ 100-200 metres ☐ Other (specify) _____	**Standing** ☐ Full abilities ☐ Up to 15 minutes ☐ 15-30 minutes ☐ Other (specify) _____	**Stair Climbing** ☐ Full abilities ☐ Up to 5 steps ☐ 5-10 steps ☐ Other (specify) _____

b.	**Sitting** ☐ Full abilities ☐ Up to 30 mins ☐ 30 min-1 hour ☐ Other (specify) _____	**Lifting Floor to Waist** ☐ Full abilities ☐ Up to 5 kgs ☐ 5-10 kgs ☐ Other (specify) _____	**Lifting Waist to Shoulder** ☐ Full abilities ☐ Up to 5 kgs ☐ 5-10 kgs ☐ Other (specify) _____
c.	Hearing: able to hear in-suite and building smoke and CO alarms ☐ Yes ☐No		**Hearing: Other relevant restrictions (specify)**
d.	**Chemicals or Scents** ☐ No restrictions/full abilities ☐ Medical reaction triggered by scent ☐ Medical reaction triggered by touch ☐ Other (specify) _____	**Chemicals or Scents: How long after exposure does reaction subside?** ☐ Within 5 minutes (e.g. of mopping floor) ☐ 5-15 minutes ☐ 15-30 minutes ☐ Other (specify) _____	**Chemicals or Scents: Distance from patient** ☐ Within 5 feet from areas patient occupies ☐ 5-20 feet from areas patient occupies ☐ Other (specify) _____
e.	**Chemicals/Scents: The following chemicals or scents cause a medical reaction (list names of chemicals and severity of reaction):**		

f.	**Environmental exposure** ☐ No restrictions/full abilities ☐ Medical reaction triggered by heat (specify temperature, duration and reaction) ☐ Medical reaction triggered cold (specify temperature, duration and reaction) ☐ Other (Specify) _____	**Noise** ☐ Within 5 feet from areas patient occupies ☐ 5-20 feet from areas patient occupies ☐ Other (specify) _____

Please provide your medical opinion with respect to the patient's

***functional restrictions* that are relevant and apply.**

If the ability is not relevant to the request, place a diagonal line through the text box.

5.	**Bending/twisting or repetitive movement** (specify) _____ _____ _____ _____ _____	**Limited use of hands**: Left ☐ gripping ☐ Right ☐ pushing/pulling ☐ ☐ twisting ☐ ☐ hand strength ☐ ☐ other (specify) ☐ _____

a.	Additional comments on **abilities** and/or **restrictions** _____ _____ _____ _____ _____	
6.	Does the patient use a mobility device that is medically required?	☐ Yes
	If yes, what mobility device(s) is required (check all that apply): ☐ Cane ☐Stationary walker	☐ No
	☐ Gurney wheelchair ☐Rolling walker	
	☐ Wheelchair stroller ☐Manual wheelchair	
	☐ Electric wheelchair ☐Scooter	
	☐ Hoyer lift	
	☐ Other (specify) _____	
7.	Is the patient currently hospitalized? If yes, is expected discharge imminent?	☐ Yes ☐ No
8.	Are the functional restrictions temporary and expected to be resolved or substantially resolved within the year (e.g. broken ankle)?	☐ Yes ☐ No
9.	Can the patient access and use the bathroom (including bathing or showering facilities) in their current unit?	☐ Yes ☐ No
a.	Can the patient use a bathtub?	☐ Yes ☐ No
b.	Does the patient require a walk-in/roll-in shower?	☐ Yes ☐ No
c.	Does the patient require additional knee clearance under the sink?	☐ Yes ☐ No

d.	For any other requirements the patient has in their bathroom, please explain further below.	
10.	Does the patient have issues with access and use the kitchen facilities in their current unit? If not, explain further in section 10 (d).	☐ Yes ☐ No
a.	Does the patient have issues with accessing their oven and fridge?	☐ Yes ☐ No
b.	Does the patient require additional knee clearance under the sink or kitchen counter?	☐ Yes ☐ No
c.	What is the patient's reach capacity (i.e. ability to access items from kitchen cupboards)? _____ _____ _____	
d.	For any other requirements the patient has in their kitchen, please explain further below.	

11.	Do the functional restrictions prevent the patient from being able to perform activities of daily living in their unit (i.e. self-care, personal hygiene, eating, making decisions, completing tasks, etc.)? If yes, please specify:	☐ Yes ☐ No
12.	In your professional opinion, do you believe that nothing short of a modified/accessible unit will result in the household member being able to perform activities of daily living in their unit?	☐ Yes ☐ No

Licensed Healthcare Professional (LHCP)

☐ GP/Family Physician ☐ Allergist/Immunologist ☐ Cardiologist ☐ Dermatologist ☐ Oncologist ☐ Ophthalmologist ☐ Psychiatrist ☐ Pulmonologist	☐ Dermatologist ☐ Rheumatologist ☐ Neurologist ☐ Clinical Psychologist ☐ Occupational Therapist ☐ Other (specify): _____
I hereby certify that this information represents my best professional judgment and is true and correct to the best of my knowledge.	**LHCP Stamp or Provincial Registration**

_____ LHCP Name (please print)

_____ Contact Telephone number

_____ LHCP Signature

_____ Date

Patient Consent

I understand that Dufferin County requires the personal information requested on this form to determine my eligibility for an accessible unit, unit modifications or other accommodation. I authorize my licensed healthcare professional to release information requested on this form to Dufferin County Housing and I consent to Dufferin County Housing using, verifying, disclosing and retaining this information, my application and any supporting documentation on my housing file to the extent it is necessary in order to respond to my request for accommodation and for related tenancy purposes. For clarity, disclosure may be to an independent medical consultant, to the tenant, to Dufferin County for the purposes of compliance with the *Housing Services* Act, etc. I understand that Dufferin County Housing will not directly contact my healthcare professional without my prior consent. I understand that if I am the patient and not the tenant that the information collected because of this form will be shared with the tenant and I consent to this disclosure.

Patient's Name (please print)*

Patient's Signature*

Tenant's Name (if not the patient)

Tenant's Phone Number

Date (mm/dd/yy)

**If the patient is under 18 or unable to provide consent in writing because of physical or mental disability, the consent must be signed by the patient's parent, legal guardian, trustee, or power of attorney for personal care and property.*