WINDSOR ESSEX
COMMUNITY HOUSING

Accessibility Medical Questionnaire

Tenants:

The Accessibility Program accommodation request is a program that requires medical information to be submitted for the request to be approved and to ensure all your medical accommodation needs are met. It provides information to approve or deny your accommodation request.

The following medical questionnaire is the document that will assist the Accessibility Program determine 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 be completed by your **licenced health care professional.**

Once it is completed, **please submit it to your site office**. It is recommended that you make a copy for your own records. If you do not have a way to make a copy, ask your property clerk to make a copy for you. Also request they date stamp your copy before returning the copy to you.

This document is your official request for medically required accessibility accommodation. You will be contacted in writing advising of your approval status shortly after you have submitted the completed Medical Questionnaire forms. This form does not guarantee you will be approved.

Accommodation / Accessibility Request

If you are a current WECHC tenant 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.

While some requests may result in a transfer to another WECHC unit, Windsor Essex Community Housing Corporation will always try to reasonably accommodate the need in the current unit before considering a transfer.

Important note to licensed healthcare professionals and their patients:

- The use of a **scooter** or **walker** does not necessarily qualify a patient for a modified unit or a transfer to another unit.
- **Modified units** provide varying degrees of modifications 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 min ☐30 min-1 hour ☐ Other (specify) _____	**Lifting Floor to Waist** ☐Full abilities ☐Up to 5 kg ☐5-10 kg ☐ Other (specify) _____	**Lifting Waist to Shoulder** ☐Full abilities ☐Up to 5 kg ☐5-10 kg ☐ 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 by 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) _____

5.	Please provide your medical opinion with respect to the patient's **functional restrictions** 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.	**Bending/twisting or repetitive movement** (specify) ☐ _____ _____ _____ _____ _____	**Limited use of hands**: Left / Right ☐ gripping ☐ ☐ pushing/pulling ☐ ☐ twisting ☐ ☐ hand strength ☐ ☐ other (specify) ☐ _____
6.	Additional comments on **abilities** and/or **restrictions** _____ _____ _____ _____ _____	
7.	Does the patient use a mobility device that is medically required? If yes, what mobility device(s) is required (check all that apply): ☐ Cane ☐ Stationary walker ☐ Gurney wheelchair ☐ Rolling walker ☐ Wheelchair stroller ☐ Manual wheelchair ☐ Electric wheelchair ☐ Scooter ☐ Hoyer lift ☐ Other (specify) _____	☐Yes ☐No
8.	Is the patient currently hospitalized? If yes, is expected discharge imminent?	☐Yes ☐No

9.	Are the functional restrictions temporary and expected to be resolved or substantially resolved within the year (e.g. broken ankle)?	☐Yes ☐No
10.	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 in section 6.	
11.	Can the patient access and use the kitchen facilities in their current unit? If no, explain further in section 6.	☐Yes ☐No
a.	Can the patient access 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 in section 6.	
12.	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, specify: _____	☐Yes ☐No

	_____ _____ _____ _____	
13.	What measures might (by the household *and* by Windsor Essex Community Housing Corporation) enable the household member to perform activities of daily living in their existing unit? _____ _____ _____ _____	
14.	If the patient is seeking a transfer to another residential unit, what are you expecting the other unit to have (that the patient's current unit does not have) that would address the needs of the patient? _____ _____ _____ _____	
15.	Is the unit causing or contributing to the impairment? If yes, how is it doing so? _____ _____	☐Yes ☐No
16.	In your professional opinion, do you believe that nothing short of a move will result in the household member being able to perform activities of daily living in their unit?	☐Yes ☐No

17.	Why does a person with this medical condition or disability need an additional bedroom? _____ _____ _____	
18.	Is a room required to store medical equipment?	☐Yes ☐No
a.	If yes, what is the medical equipment? _____	
b.	What are the dimensions of the medical equipment? _____	
c.	The bedroom(s) in this unit are the following size(s) (WECHC STAFF TO COMPLETE):	
d.	Can the medical equipment reasonably be accommodated in the current unit? If no, please explain why, and explain what square footage is required: _____	☐Yes ☐No
19.	Does your patient's disability require them to have a separate bedroom to accommodate a full-time overnight caregiver who is not part of the household? If yes, what services do they require? _____ _____	☐Yes ☐No
20.	Is the need for full-time overnight care long-term? If no, how long will the patient need overnight care? _____ _____	☐Yes ☐No
If a full-time overnight caregiver is required, the household must also complete the Home Care Agency's Verification Form, or the Caregiver's Verification Form if the caregiver is not affiliated with a home care agency.		

Licensed Healthcare Professional (LHCP)

I am a (check box that applies):

- ☐ GP/Family Physician
- ☐ Allergist/Immunologist
- ☐ Cardiologist
- ☐ Dermatologist
- ☐ Neurologist
- ☐ Occupational Therapist
- ☐ Oncologist
- ☐ Ophthalmologist
- ☐ Psychiatrist
- ☐ Pulmonologist
- ☐ Rheumatologist
- ☐ 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 Tel. Number

_____ LHCP Signature

_____ Date (mm/dd/yyyy)

Patient Consent

I understand that Windsor Essex Community Housing Corporation 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 Windsor Essex Community Housing Corporation and I consent to Windsor Essex Community Housing Corporation 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 the City of Windsor for the purposes of compliance with the *Housing Services Act*, etc.

I understand that Windsor Essex Community Housing Corporation 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 as a result of this form will be shared with the tenant and I consent to this disclosure.

_____ _____

Patient's Name Patient's Signature

_____ _____

Tenant ID Number Date (mm/dd/yyyy)

**If the patient is under 18 or unable to provide consent in writing by reason 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.*

The personal information on this form is collected under the authority of the Human Rights Code, RSO 1990, c H19 including sections 10, 11 and 17 of that act; the Housing Services Act, 2011, SO 2011, c 6 Sched 1 including section 176 of that act and O Reg 367/11 including section 47(1) 5 of that regulation; and/or the Residential Tenancies Act, 2006, SO 2006, c 17 including section 10 of that act, and will be used only as is necessary for the purposes of determining an applicant's eligibility for an accessible unit, modifications to their current unit, transfers to another unit, and/or other accessibility/accommodation measures related to the tenancy. If you have any questions about the collection of this information, please contact Windsor Essex Community Housing Corporation at 519-254-1681.