Windsor Essex Community Housing Corporation
945 McDougall, Windsor, Ontario, N9A 1L9
Phone: 519-254-1681 Fax: 519-254-3130 E-Mail: info@wechc.com

MEDICAL REPORT

(To be completed by a medical professional)

PLEASE PRINT LEGIBLY

Name of Individual Completing Report: _____
Identify Medical Profession: Physician ____ Nurse Practitioner ____ Nurse ____
Other (specify) _____
Address: _____

Patient's Name: _____

RELEASE BY PATIENT

I hereby authorize the release of any required medical information to **Windsor Essex Community Housing Corporation.**

_____ _____
Signature of Patient Date

Note to Medical Professional:
Your patient has requested an alternate unit based on a medical condition. To help us determine if they meet our criteria for a medical transfer please complete this form. *It is essential that you are as specific as possible in your evaluation.* The information provided will assist us in assessing the request and to determine if we have an appropriate type of unit within our portfolio. Due to the limited availability of appropriate units, medical transfers are restricted to residents with permanent and severe health issues. Thank you.

DIAGNOSIS:

_____
_____

DATE OF INITIAL DIAGNOSIS: _____

PROGNOSIS:

_____
_____

If patient's health problems are affected by the present accommodation, please outline the impact.

_____
_____

How will alternate accommodation improve/stabilize the patient's medical status?

Explain:_____
_____

In your opinion, how do you feel patient's 'functional ability' will be affected by alternate housing, i.e. coping with ordinary physical necessities of life such as mobility, personal hygiene, housekeeping, cooking, etc.?

_____Improve _____Stabilize _____Deteriorate
_____ No change

Does patient have any other special consideration with regard to accommodation? If so, please explain:

_____

Is patient capable of living independently? _____yes _____no
If no, is patient capable of living independently with support service? _____yes _____no
If yes, what if any support services are required (i.e. homemaking, CCAC, etc.) and are they in place?
_____

What type(s) of accommodation would be required to meet patient's health needs? Please be as specific as possible (i.e elevator access, handicap accessible apartment, modified apartment). **Check all that apply.**

____ limited stairs (split level with 6 stairs to bathroom and bedrooms, availability limited).

____ bathroom on main level (2 story with 1/2 bathroom on first floor and full bathroom/ bedrooms on 2nd floor). Has stairs to get into the unit and stairs to the bedrooms.

____ bedroom and bathroom on the main floor. Has stairs to get into the unit and to the basement.

____ single level inside. **Has stairs** to get into the unit. (very limited)

____ no stairs (apartments)

(Not all unit types are available in all unit sizes.)

Other Considerations or concerns:
_____
_____

I certify that the above is true and correct to the best of my knowledge.

Medical Professional's Signature: _____

Phone Number: (___) _____ Date:_____