Medical Questionnaire Form

Important note to licensed healthcare professionals and their patients:

Your patient is requesting an accessible unit, unit modifications, or other accommodation from Toronto Community Housing (TCHC). Please note the following:

- The purpose of the Medical Questionnaire and the information you provide us is to allow TCHC to understand the patient's disability(ies).
- **Please provide as much detailed information as possible about the specific restrictions and limitations associated with the disability(ies) and how their unit causes or contributes to their disability(ies).**
- We will use this information to work with the tenant to determine a reasonable accommodation in the circumstances.
- 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.
- **Availability of units** is extremely limited within TCHC.

Accommodation/accessibility

To be completed by a licensed healthcare professional 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 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. If the ability is not relevant to the request, place a diagonal line through the text box. Include additional details in section 6.		
a.	**Walking** ☐ Full abilities ☐ Restrictions (specify):	**Standing** ☐ Full abilities ☐ Restrictions (specify):	**Stair climbing** ☐ Full abilities ☐ Restrictions (specify):
b.	**Sitting** ☐ Full abilities ☐ Restrictions (specify):	**Lifting floor to waist** ☐ Full abilities ☐ Restrictions (specify):	**Lifting waist to shoulder** ☐ Full abilities ☐ Restrictions (specify):

<table>
<tr><td>c.</td><td>Bending/twisting or repetitive movement

☐ Full abilities
☐ Restrictions (specify):</td><td colspan="2">Limited use of hands:
<table><tr><td>Left hand</td><td>Right hand</td></tr><tr><td>☐ Full abilities</td><td>☐ Full abilities</td></tr><tr><td>☐ Gripping</td><td>☐ Gripping</td></tr><tr><td>☐ Pinching</td><td>☐ Pinching</td></tr><tr><td>☐ Pushing/pulling</td><td>☐ Pushing/pulling</td></tr><tr><td>☐ Other (specify):</td><td>☐ Other (specify):</td></tr></table></td></tr>
<tr><td></td><td colspan="3">Additional comments on abilities:</td></tr>
<tr><td>5.</td><td colspan="3">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. Include additional details in section 6.</td></tr>
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	Hearing ☐ No reaction ☐ Other (specify):
	Chemicals or scents ☐ No reaction ☐ Other (specify):
	Environmental exposure (noise, allergens, etc.) ☐ No reaction ☐ Other (specify):
	Does the patient have any **restrictions or limitations arising from non-physical disabilities**? (For example, mental health, addiction, cognitive or intellectual disabilities.) ☐ Full abilities ☐ Restrictions (specify):

	What situations or circumstances in the patient's unit or tenancy cause or contribute to the restrictions arising from the patient's non-physical disability?	
6.	Additional information on **restrictions:**	
	Does the patient use a mobility device that is medically required?	☐ Yes ☐ No
	If yes, what mobility device(s) is required (check all that apply): ☐ Cane ☐ Gurney wheelchair ☐ Wheelchair stroller ☐ Power wheelchair ☐ Hoyer lift ☐ Stationary walker ☐ Rolling walker ☐ Manual wheelchair ☐ Scooter ☐ Other (specify): ________________________	

	Is the patient currently hospitalized? If yes, is expected discharge imminent?	☐Yes ☐No
7.	Are the functional restrictions temporary and expected to be resolved or substantially resolved within the year? (For example, a broken ankle.)	☐Yes ☐No
8.	Do the functional restrictions prevent the patient from being able to perform activities of daily living in their current unit (like self-care, personal hygiene, eating, completing tasks, etc.)? If yes, specify:	☐Yes ☐No
9.	What measures might address the patient's functional restrictions and limitations in their unit or tenancy, and how will those measures do so?	

Specific information related to request for additional bedroom

Important note to licensed healthcare professionals and their patients:

The City of Toronto has established Local Occupancy Standards for rent-geared-to income housing. These Standards permit a household to qualify for an extra bedroom if:

A. A spouse who would normally share a bedroom requires a separate bedroom because of a disability. Spouses will not normally qualify for an additional bedroom unless a second bed cannot be accommodated within a shared bedroom.

   A household will not qualify for an additional bedroom based on a snoring condition alone.

B. A room is required to store equipment that a member of the household needs because of a permanent disability, and the equipment is too large to be reasonably accommodated in a unit size for which the household would normally qualify. The following equipment will not normally qualify a household for an additional bedroom:

   i. continuous positive airway pressure (CPAP) machines;
   ii. air-filtration systems;
   iii. vaporizers or humidifiers;
   iv. walkers, wheelchairs, or scooters;
   v. massage tables; or
   vi. exercise equipment.

C. An additional bedroom is required for an individual who is not a member of the household, but who occupies the unit to provide full-time overnight support services to a member of the household. The household must also submit the Caregiver application forms with these types of requests.

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When a household requests an extra bedroom for a medical reason, Toronto Community Housing must determine if the household qualifies under the Local Occupancy Standards. From time to time, Toronto Community Housing may ask for new information to verify that the household still qualifies for the extra bedroom.

If the patient is requesting an additional bedroom, please complete the following along with the other information requested above in this form:

10.	What restrictions or limitations does the patient have that may require an additional bedroom?	
11.	Is extra room required to store medical equipment?	☐Yes ☐No
	If yes, what is the medical equipment?	
	What are the dimensions of the medical equipment?	
12.	Does your patient's disability require them to have a full-time overnight caregiver?	☐Yes ☐No
	If yes, what services do they require and how often throughout the night?	
13.	Is the need for full-time overnight care long-term?	☐Yes ☐No
	If no, how long will the patient need overnight care?	

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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
- ☐ Clinical Psychologist
- ☐ 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 phone number
______________________________ LHCP signature	______________________________ Date (mm/dd/yy)

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Patient consent

I understand that Toronto 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 Toronto Community Housing Corporation and I consent to Toronto 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. I understand that Toronto Community 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 as a result 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
______________________________	______________________________
Tenant Account Number	Date (mm/dd/yy)

**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, pursuant to the *Housing Services Act (2011)* or the *Municipal Freedom of Information and Protection of Privacy Act,*

(R.S.O. 1990, c M.56) 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 Toronto Community Housing's Information Specialist at 931 Yonge Street, Toronto, ON, M4W 2H2, or **416-981-5500** (TRS **7-1-1**).