



MEDICAL VERIFICATION FORM

For office use only: Tenant #: _____

Patient Name: _____

Address: _____

_____ Telephone: _____

Consent and Release from Patient

I hereby authorize my physician to release any medical information to the Regional Municipality of York, Community and Health Services Department and Housing York Inc.

I hereby give permission for this information to be retained on file by the Regional Municipality of York, Community and Health Services Department and Housing York Inc.

Patient's signature

Date

Important Note to Physicians:

Your patient is requesting a transfer from one rental unit to another. A transfer request for medical reasons falls into one of the following categories. Please check the appropriate box and complete the corresponding section:

Part A : Additional Bedroom Request

Part B: Modified Unit

Part C: General Health & Well Being Request

PART A: ADDITIONAL BEDROOM REQUEST

Your patient is requesting an additional bedroom, they may qualify if:

- a) Spouses cannot share a bedroom due to a disability or medical concern
- b) Additional space is required to store medical equipment needed because a member of the household has a disability or significant medical condition.

1) Does your patient have a medical condition that will adversely affect the health of one or both spouses by sharing a bedroom?

Yes No

1a) If yes, please explain how separate bedrooms would improve the patient's prognosis.

2) As a result of the medical condition does the patient require space to store medical supplies or medical equipment? Yes No

If yes, please check the boxes that apply:

- | | |
|-----------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Commode chair | <input type="checkbox"/> Scooter |
| <input type="checkbox"/> Oxygen tanks | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Hover lift | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Nebulizer/compressor | <input type="checkbox"/> Other (please explain): _____ |

PART B: MODIFIED UNIT REQUEST

Your patient is requesting an accessible unit which will have varying degrees of modifications (i.e. widened doorways, hallways, roll-in shower, etc...)

1) Does your patient require a mobility aid (e.g. wheelchair, scooter, walker)?

Yes No

2) In what situations does your patient use the mobility aid? Please explain.

3) Does your patient have a deteriorating medical condition that will increase the need for unit modifications? If yes, please explain.

PART C: GENERAL HEALTH & WELL BEING REQUEST

Your patient is requesting a transfer to a different unit due to medical reasons.

1) How is the patient's existing unit having an adverse affect on the patient's health?

2) Please explain how a transfer to a different unit would improve the patient's prognosis?

<p>Physician's Release: I hereby certify that this information represents my best professional judgment and is true and correct to the best of my knowledge.</p> <p>_____</p> <p>Physician's Name (printed)</p> <p>_____</p> <p>Physician's signature</p> <p style="text-align: right;">Contact Tel # _____</p>	<p>SPACE FOR PHYSICIAN'S STAMP</p>
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The personal health information disclosed on this form will be used only for the purpose of determining a tenant's eligibility for an internal transfer and is collected under the authority of the Social Housing Reform Act, 2000. In applying for a transfer to another rent-geared-to-income unit,, the applicant consents to the collection, use and disclosure, including verification, of the information provided to the Regional Municipality of York in their application or supporting documents.