



SOCIAL HOUSING ATTENDING PHYSICIAN'S REPORT

Applicant's Name:

Patient's Name:

Address:

Physician's Name: (please print) _____

IMPORTANT NOTE TO PHYSICIAN:

Your patient has applied for housing/ housing transfer on medical grounds. The information which you provide will assist us in appropriately assessing the application. In order to be given consideration for housing under a medical priority, the applicant must meet the following criteria:

Serious medical, health and or social needs which would result in severe hardship or personal risk to the applicant if she/he were required to wait a prolonged period of time to access housing.

RELEASE BY PATIENT:

I hereby authorize my physician to release any required medical information to the Algoma District Services Administration Board.

Signature:

_____ **Date:** _____

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DIAGNOSIS:

PROGNOSIS:

SECONDARY DIAGNOSIS:

Which of the following would categorize the patient's medical status?

- Life Threatening and/or degenerative
- Chronic but not life threatening
- Short term duration

Are the current health problems aggravated by the patient's present accommodation? Please explain.

Do you feel that your patient is capable of living independently, in a self-contained unit?

- Yes
- No
- with Support

Explain the services that are or will be in place to ensure the independent living of your patient:

If your diagnosis indicates behavioral/psychological problems that might be considered anti-social, violent, destructive, or self-destructive, please explain:

PHYSICIAN'S CERTIFICATION:

I certify that this information represents my best professional judgment and is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Address: _____ Phone: _____

The physician may give this form directly to the patient or mail to:

Algoma District Services Administration Board
RR#1, 1 Collver Road, Thessalon, ON P0R 1L0

Att: Program Assistant