

<b>Patient consent and release</b> <i>To be completed by applicant/patient</i>			
<i>I understand that Housing Connections requires the requested personal health information to determine my eligibility for priority for the terminally ill. I authorize my physician to release the information requested on this form to Housing Connections, and I consent to Housing Connections using, verifying and retaining this information on my housing file.</i>			
Patient name:			
Application number:			
Patient signature:		Date:	
<b>Privacy statement</b>			
<i>The personal health information disclosed on this form will be used only for the purposes of determining an applicant's eligibility for priority for the terminally ill. It is collected under the authority of the Housing Services Act, 2011, c.6. In applying for rent-geared-to-income housing and/or the applicant's request for priority for the terminally ill, the applicant consents to the collection, use and disclosure, including verification, of the information provided to Housing Connections in their application or supporting documents.</i>			
<b>Diagnosis</b> <i>To be completed by patient's physician</i>			
<b>Important note to physicians:</b> Your patient is requesting priority for rent-geared-to-income housing in Toronto which is specifically reserved for <b>applicants who have less than two years to live</b> . Housing Connections requires medical documentation outlining the patient's diagnosis and life expectancy. <i>Please print, use plain language, and avoid abbreviations or acronyms.</i>			
Patient name:			
Patient address:			
How long has this patient been under your care?			
Diagnosis of illness:			
Life expectancy is:	<input type="checkbox"/> Less than two years <input type="checkbox"/> More than two years		
Please provide any additional relevant information about the prognosis (please print):			

Is the patient in a wheelchair?  Yes  No  
 If *yes*, the patient is in the wheelchair  full-time  part-time

Does the patient require modifications to their accommodation to manage the activities of daily living?  Yes  No  
 If *yes*, identify the required modifications: \_\_\_\_\_

Does your patient's disability or medical condition require him or her to have a separate bedroom to store and/or operate medical equipment?  Yes  No  
 If *yes*, what is the medical equipment? \_\_\_\_\_

Does your patient's disability or medical condition require him or her to have a separate bedroom because the room is required for an overnight caregiver (who is not part of the household)?  Yes  No

**Ability to live independently**

Is your patient able to manage the activities of daily living without assistance?  
 Yes  No If *no*, what supports does the patient need? \_\_\_\_\_

Are these supports in place?  Yes  No

**Physician's authorization**

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

Physician's name:			
Physician's signature:		Date:	
Physician's telephone:			