Patients name: _____
Address: _____
Phone number: _____

Office d'habitation de l'Outaouais

Medical Attestation

Attribution of particular accommodation

PLEASE HAVE THIS FORM COMPLETED BY THE DOCTOR OR THE OCCUPATIONAL THERAPIST

Your patient, in the reason of health problems, desires:

☐ *transferring from his/her current accommodation towards another that meets his/her particular needs*

☐ *Obtain an accommodations that meets his/her particular needs*

☐ *Obtain an accommodations without carpet (complete part 4 of this form)*

For that, we need a medical justification. Please complete this short form.

PART 1 – STATE OF HEALTH

- What disease or health problem justifies this request? : _____
  _____
  _____
  _____
- Does the patient have a motor or sensory handicap? Yes☐ No☐
  If yes, please specify: _____
- Is the disease, disorder, or disability of your patient of evolutionary nature?
  Yes☐ No☐
- Does the patient have the ability to go up and down stairs? Yes☐ No☐
  If yes, please be precise as to how many stairs: _____

PART 2 – NECESARY TECHNICAL HELP

- Does the patient use a technical aid such as (check the applicable options) :

  ☐ Cane, crutches, walker ☐ *Lift*

  ☐ Manual wheelchair or electric ☐ *Hospital bed*

  ☐ Scooter, quadriporteur ☐ *Other:*_____

- Does the patient need for care/help to carry out its activities of daily living. (ADL)?
  Yes☐ No☐
- If yes, does the patient receive help to perform his/her ADL from « Le Centre de santé et de services sociaux (CSSS) »? Yes☐ No☐
- If yes, what services are offered? _____
  _____
  _____
- Does the patient require a caregiver to reside with him/her to help carry out his/her ADL?
  Yes☐ No☐

PART 3 – SPECIAL NEEDS IN TERMS OF HOUSING

- If the patient uses a device for his/her displacements, what is its maximum width?:_____
- Does the patient have the ability to open the doors without help? Yes ☐ No ☐
- Can the patient operate daily in a kitchen with the cabinets and the countertops of standard height?

  Yes ☐ No ☐
- Can the patient use a standard size toilette on a daily basis?

  Yes ☐ No ☐
- Can the patient use a bath tub to perform his/her corporal hygiene care?

  Yes ☐ No ☐
- Does the patient have other special needs in terms of housing? : _____
  _____
  _____
  _____
- Does the patient have access to the services of an occupational therapist? Yes ☐ No ☐
  If yes, what is their name? :_____

PART 4 – HEALTH PROBLEMS RELATED TO THE PRESENCE OF CARPETS IN THE HOUSING

- Does the patient have asthma? Yes ☐ No ☐
- Does the patient suffer from allergies or other health problems directly related to the presence of carpet?

  Yes ☐ No ☐

  If yes, please specify: _____
- If the patient has symptoms of allergies that may be caused by the presence of carpet, has this been confirmed by a test done by an allergist? Yes ☐ No ☐
- Does the presence of carpet hurt the patient's mobility? Yes ☐ No ☐
- Would the withdrawal of carpet improve the patients health condition related to the problems mentioned above?

  Yes ☐ No ☐

  In what way? : _____
- Have other preventive measures been implemented (ex.: mattress covers, hypoallergenic bedding, removal of animals, etc.) Yes ☐ No ☐

ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

_____ _____

Name of the health care professional | Practice number or of profession

_____ _____

Signature of the health care professional | Telephone number

_____

Date

For any questions or information related to this form, please contact Anne-Marie Finlay 819-568-0033 ext. 524