NCHC
Northumberland County Housing Corporation

Limitations Assessment Form

Important Note to the Health Professional

Your patient has applied for social housing, and this form requires completion for one of the following reasons: to verify your patient's ability to live independently; to identify what supports are required to enable your patient to live independently; or to verify their need for a modified/wheelchair accessible unit. The information that you provide will allow Northumberland County Housing Division to determine whether our housing program can accommodate your patient's needs.

Patient Details

First Name

Middle Name

Last Name

Street Address

Unit Number

City/Town

Province

Postal Code

Release by Patient

I hereby authorize my physician/health care professional to release and clarify the following medical details to Northumberland County Housing Services and I understand that such information is **confidentially** retained in my file.

Patient's Signature

Date of Signature

Details

Please provide details of the patient's medical condition and the affects it has on their housing needs.

Is the patient's mobility restricted?

- [ ] Yes
- [ ] No

If yes, please provide details below.

Is the patient's current accommodation exacerbating their medical condition?

- [ ] Yes
- [ ] No

If yes, please provide details below.

Does the patient need accommodation that is modified?

- [ ] Yes
- [ ] No

If yes, please provide details below.

Is the patient able to accept a second floor unit and be able to live independently without a lift (elevator)?

- [ ] Yes
- [ ] No

If no, please provide details.

Limitations

Does the patient have any of the following limitations:

External (lifting, carrying, standing, walking, sitting, pushing, pulling)

☐ Yes ☐ No

Comments

Manipulative (reaching, feeling, gripping)

☐ Yes ☐ No

Comments

Visual

☐ Yes ☐ No

Comments

Communicative (hearing, speaking)

☐ Yes ☐ No

Comments

Mobility

Equipment

Is any mobility equipment used? (wheelchair, walking stick, walking frame, electric scooter, etc.)

Comments

☐ Yes ☐ No

Is mobility equipment needed indoors?

Comments

☐ Yes ☐ No

Is mobility equipment needed outdoors?

Comments

☐ Yes ☐ No

Is mobility equipment needed all the time?

Comments

☐ Yes ☐ No

Walking

☐ Patient has no difficulty walking.

☐ Patient has slight difficulty walking.

☐ Patient cannot walk at all.

Stairs

☐ Patient has no difficulty with stairs.

☐ Patient has slight difficulty with stairs.

☐ Patient cannot climb stairs at all.

If the patient can manage stairs, how many stairs can the patient manage?

☐ 1-2 ☐ 3-5 ☐ 6-12 ☐ 12 or more

Please provide any additional information that might be helpful.

Physician/Health Care Professional Release

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

Physician/Health Care Name (please print)

Phone Number

Physician/Health Care Professional Signature

Date of Signature

Thank You

Please print and submit a signed copy of this form to Northumberland County Community and Social Services. The Limitations Assessment Form can be submitted by:

- email to: css@northumberlandcounty.ca
- mail to: 555 Courthouse Road, Cobourg, ON K9A 5J6