

# Appendix 5 Medical Assessment Form



Date of issue        /        /

Application Number: \_\_\_\_\_

If you need help completing this form please contact your local office.

You should give full details of any medical condition, how your current home affects your medical condition and how re-housing might improve your condition.

If more than one member of your household has a medical condition, a separate form must be completed for each person.

Please enclose any letters that you have from GPs, hospitals, health visitors or Social Services to support your medical application. This will help us to carry out a fuller assessment of your case.



Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_



**1. What medical problems do you have?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 2. Is your condition

getting better?                       getting worse?                       staying the same?

Explain why and how: \_\_\_\_\_

**3. What medications are you using?** \_\_\_\_\_

\_\_\_\_\_

**4. Your doctor's details**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone number: \_\_\_\_\_

**5. Do you use:**

Please tick as appropriate	Inside	Outside
a wheelchair		
a walking stick		
a walking frame		
an adapted vehicle		

**6. Do you get breathless when walking or climbing stairs?**

Yes     No

**7. Is it painful to climb stairs?**

Yes     No

**8. Do you need to live on the ground floor?**

Yes     No

**9. Do you need help with any of the following?**

Please tick as appropriate	Yes	No
Bathing		
Housework		
Cooking		
Shopping		

**10. Are you applying to move in order to get help from another person?**

If so, tell us where they live and their relationship to you. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**11. Please tick if you have had support in the last two years from any of the following:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Care assistant              | <input type="checkbox"/> Hospital consultant | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Community psychiatric nurse | <input type="checkbox"/> Social worker       | <input type="checkbox"/> Meals on Wheels        |
| <input type="checkbox"/> District nurse              | <input type="checkbox"/> Health visitor      |   |

**12. Please tick if you receive any of the following benefits**

- |   |  |
|---|--|
| <input type="checkbox"/> Incapacity Benefit                   | <input type="checkbox"/> Industrial Injuries Disablement Benefit |
| <input type="checkbox"/> Attendance Allowance                 | <input type="checkbox"/> Disability Living Allowance Care        |
| <input type="checkbox"/> Disability Living Allowance Mobility | <input type="checkbox"/> Severe Disablement Allowance            |

**13. Has your current home been adapted for residents with disabilities or long term medical conditions?** Please tick which adaptations.

- |                                     |   |                                     |
|-------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Grab rails | <input type="checkbox"/> Floor-level shower | <input type="checkbox"/> Stair lift |
| <input type="checkbox"/> Ramp       | <input type="checkbox"/> Other adaptations  |                                     |

**14. Would you need these adaptations in a new home?**

- Yes     No

**15. Does your present home affect your health? If so, how?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**16. Do you have a history of falls and/or a fear of falling that is affecting how you live your life?** \_\_\_\_\_

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**17. Please give any other information that might be relevant to your application.**

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I certify that the information given above is correct to the best of my knowledge. I understand that if I am allocated a tenancy on the basis of false information, Metropolitan Housing Partnership reserves the right to terminate the tenancy.

I understand that the information provided on this form is subject to the Data Protection Act 1998.

I will inform Metropolitan Housing Partnership of any changes in my circumstances.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

