

Medical Assessment Form

Please complete this form if you, or a member of your household, suffer from a **SERIOUS ILLNESS OR DISABILITY**, which is affected by your housing and for which you are receiving treatment.

This form is for **YOU** to complete. **PLEASE DO NOT TAKE IT TO YOUR DOCTOR.**

The Council's Independent Medical Adviser will assess the information you provide. The purpose of the assessment is to determine whether the illness or disability necessitates a move to more suitable accommodation/ He/she may need to contact your doctor for further information. We need your permission to do this and would ask you to sign the consent below, without which we may be unable to process your application.

Applicant's name

Address

Please give the name and address of your doctor and or the hospital consultant (as appropriate).

Doctor's name

Telephone number

Address

Hospital consultant's name

Telephone number

Address

CONSENT

I authorise the Council's Medical Adviser to contact my doctor and/or hospital consultant for the purpose of making a medical assessment in connection with my housing application.

Applicant's signature

Date

ILLNESS/DISABILITY

Please tick (✓) appropriate box(es)

Please provide details of the people in your household whose medical condition you feel should be taken into account. If more than two people are affected, please continue on a separate sheet.

	First person	Second person
Surname		
First name		
Date of birth		
Details of medical condition or disability		
Has the doctor (or consultant) prescribed any medicines for this condition?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, give the names of the medicines (if you know them) and state how often they are taken.		
Has the person named above attended hospital during the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES was this as an In-patient or an Out-patient?		
Which hospital was attended?		
Why was hospital attended?		
If you have submitted a previous assessment form within the past year, please describe how your medical circumstances have changed during this period.		
Is any further treatment or operation planned?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

PRESENT ACCOMMODATION

Please tick (✓) appropriate box(es)

Housing type

Do you live in a:	
Bungalow	
House	
Flat (self-contained)	
Flat (shared facilities)	
Hotel / Hostel	
Caravan	
Other (please state)	

Floor level

On which floor is your front door:	
Basement	
Ground	
First	
Second	
Third or higher	
If third or higher please specify floor level	

Access

Do you have:

A lift or lifts providing access to your accommodation YES NO

Stairs inside your property YES NO

If YES how many steps

Steps to your front door YES NO

If YES how many steps

Heating

What is your main form of heating in the following rooms		
Central heating radiators		
Storage heaters		
Warm air heating		
Underfloor heating		
Gas fire(s)		
Electric fire(s)		
Solid fuel (e.g. coal)		
None		
Other (please specify)		

Adaptations

Has your property been adapted in any of the following ways:

Ramps to entrance YES NO

Stair lift YES NO

Other YES NO

If YES to other please specify

Have you been in contact with the Council's Occupational Therapy Service about adaptations? YES NO

Adaptations

Is there anything else about the condition of your home which you feel seriously aggravates the illness or disability.

Have you discussed this problem with your landlord? YES NO

Mobility

Are you able to:-	First person			Second person		
	With no difficulty	With some difficulty	Not at all	With no difficulty	With some difficulty	Not at all
A. Get round your home generally						
B. Get from front door to kitchen						
C. Get from bedroom to toilet/bathroom						
D. Get from the street to your front door						
E. Use internal stairs						

Please tick (✓) appropriate box(es)

Are any of the following usually used	First person		Second person	
	In your home	Outside	In your home	Outside
Walking stick				
Walking frame				
Wheelchair				

Are there any rooms in your home which cannot be used by either of the people mentioned above, if so, why is that?

BENEFITS AND SERVICES

Are any household members named above receiving:

	First person	Second person
Disabled Living Allowance - Care		
Disabled Living Allowance - Mobility		
Invalid care allowance		
Severe disablement allowance		
Home Carer		
District Nurse		
Community Psychiatric Nurse		
Social Worker		
Meals on Wheels		
Attendance allowance		
Occupational Therapist		

What do the people named on this form find particularly difficult about living in your current accommodation?

Signature of applicant

Date

/ /

Once completed, please return this form to:-

Wandsworth Council, Housing and Regeneration, 90 Putney Bridge Road, Wandsworth, SW18 AHR