Medical Assessment Form

DETAILS OF PERSON REQUIRING MEDICAL ASSSESMENT

Name:

Address:

Phone number: | Date of Birth:

Is this person the main applicant? ☐ Yes ☐ No

If **No**, whose name is the transfer application under?

Name:

What is their relationship to you?

FOR OFFICE USE ONLY

Category:
(Please circle)

URGENT/ NON-URGENT

Signed:

Name:

Date:

About your present home

How many bedrooms do you have?

☐ Bedsit ☐ One ☐ Two ☐ Three ☐ Four or more

How many steps up or down to the front of your building?

If you live in a block, what floor level is your home on?

☐ Basement ☐ Ground ☐ First ☐ Second ☐ Third ☐ Fourth or above

Is there a lift? ☐ Yes ☐ No

If NO, how many steps are there from the entrance to your own front door?

Do you have an intercom/entry-phone? ☐ Yes ☐ No

MEDICAL DETAILS

Please list all medical conditions that are affected by your current housing and continue on another page if necessary:

Illness/condition	Treatment	Length of time that you have had the condition. Please also state whether this is on going.
1.		
2.		
3.		

Do you have to use specialist medical equipment at home, for example, oxygen equipment, or dialysis machines?

☐ Yes ☐ No

If yes, please give details:

Do you have difficulty walking indoors?

☐ No ☐ A little ☐ A lot

Do you have difficulty walking outdoors?

☐ No ☐ A little ☐ A lot

Do you use a walking aid? ☐ Stick ☐ Crutches ☐ Frame

Do you use a wheelchair indoors? ☐ Always ☐ Sometimes ☐ No

Do you use a wheelchair outdoors? ☐ Always ☐ Sometimes ☐ No

How many steps can you manage without having to rest?

☐ None ☐ 1 – 2 steps ☐ 1 flight (about 12 steps) ☐ 2 flights (about 24 steps)

☐ 3 flights (about 36 steps or more).

Do you need a carer to live with you all the time because of your medical condition?

☐ Yes ☐ No ☐ Sometimes

Please tell us how your current home directly affects the medical condition that you have told us about.

AUTHORISATION TO DISCLOSE INFORMATION

I am aware that ARHAG Housing Association may need to make further enquiries to assess this application fully. I give consent for relevant medical or social information to be sought from, and disclosed by, the appropriate contacted. I understand that it is an offence to provide fraudulent information.

If a medical report is sought, you will receive a letter notifying you of your right under the Access to Medical Reports Act 1988 to see the report before it is sent. A medical assessment will be undertaken on the information provided. All information obtained will be dealt with confidentially in accordance with the Data Protection Act 1988.

Signed ____Date_____________________________

Name (in capitals)____

If someone has filled in this form for you, please give their name and their relationship to you.

____

CONTACT DETAILS

Name of your GP:
Address
Phone number:
When did you register with this GP?
When did you last visit this GP?

Details of any other health professional who could be contacted, for example, hospital consultant, occupational therapist, mental health worker, osteopath or district nurse	
Name:	Name:
Address:	Address:
Phone number:	Phone number:

Details of other professionals who could be contacted, for example, social worker, substance misuse worker.
Name:
Address:
Phone number: