Medical Assessment Form

For Office use only:

Application Reference: _____

Date received: _____

Once completed please return the form to: housingoptions@sholland.gov.uk

Please provide a patient summary from your GP along with this form as this will evidence any diagnosed medical conditions and prescriptions.

Applicant's Details:

Name _____

Address _____

Date of Birth _____ Telephone number _____

Name and surgery of GP: _____

Name of person who is disabled/has ill health if different from above:

Name _____ Date of Birth _____

Relationship to applicant _____

If more than one person has a medical condition, separate forms will need to be completed for each person.

Section 1 – Physical health problems

1) Do you have any physical health problems?

Yes ☐ No ☐ If YES, please provide details in the table below. If NO, please go to Section 2.

Name/description of health problem	How this affects you on a daily basis	How long you have had this health problem

2) Do you currently take any medication? Yes ☐ No ☐

If YES, please complete the table below and provide us with a copy of your prescription

Medication	Dosage	Where do you get this medication from? e.g.GP prescription, hospital, chemist

3) If you are not taking any medication at present, please list any medication that you have taken within the last 6 months.

Medication	Dosage	Where did you get this medication from? e.g.GP, hospital, chemist

4) If you take medication, do you take it yourself or does someone else manage it for you?

☐ Take medication myself ☐ Medication managed by someone else (please provide details)

_____

_____

5) Are you seeing a health specialist or attending a treatment centre regularly? Yes ☐ No ☐

If YES, please provide details in the table below

Name of health specialist and address	Telephone number	How often you see them

6) Do you use any specialised equipment to manage your illness (walking stick, wheelchair etc.)?

Yes ☐ No ☐ If YES, please provide details in the table below

Equipment	Where you use this e.g. only indoors, when shopping etc

7) How do you travel to and from appointments/visits? (e.g. bus, walk, cycle, car?)

_____

_____

8) Can you use public transport? Yes ☐ No ☐

If NO, please explain why

_____

_____

Section 2 – Mental health problems

1) Do you have any mental health problems?

Yes ☐ No ☐ If YES, please provide details in the table below. If NO, please go to Section 3.

Name/description of health problem	How this affects you on a daily basis	How long you have had this health problem

2) Do you currently take any medication? Yes ☐ No ☐

If YES, please complete the table below and provide us with a copy of your prescription

Medication	Dosage	Where do you get this medication from? e.g.GP prescription, hospital, chemist

3) If you are not taking any medication at present, please list any medication that you have taken within the last 6 months.

Medication	Dosage	Where did you get this medication from? e.g.GP prescription, hospital, chemist

4) Do you take the medication yourself or does someone else manage it for you?

☐ Take medication myself ☐ Medication managed by someone else (please provide details)

_____

5) Are you seeing a health specialist or attending a treatment centre regularly? Yes ☐ No ☐

If YES, please provide their details in the table below

Name of health specialist and address	Telephone number	How often you see them

6) Have you been referred to a mental health team? Yes ☐ No ☐

If YES, please provide more information

_____

_____

7) Are your mental health problems linked to the anxiety of facing homelessness? Yes ☐ No ☐

8) Have you ever deliberately tried to hurt yourself? Yes ☐ No ☐

If YES, please provide more information

_____

9) How do you travel to and from appointments/visits? (e.g. bus, walk, cycle, car?)

_____

_____

10) Can you use public transport? Yes ☐ No ☐

If NO, please explain why

_____

_____

Hospital admissions/involvement

1) Are you a current hospital In-Patient or Day Patient or Out-Patient? Yes ☐ No ☐

If YES, please provide more information

_____

_____

_____

2) Have you ever been admitted to hospital for your mental health? Yes ☐ No ☐

If YES, please provide more information including dates and why you were admitted

_____

_____

_____

3) Were you referred to any community-based services when you left hospital? (e.g. Community Mental Health Team) Yes ☐ No ☐

If YES, please provide more information

_____

_____

_____

_____

Section 3 – Learning disabilities

1) Do you have a learning disability / difficulty?

Yes ☐ No ☐ If YES, please provide details in the table below. If NO, please go to Section 4.

Name/description of learning difficulty	How this affects you on a daily basis	When was this diagnosed?

2) Do you receive support from any professionals for your learning difficulty?

Yes ☐ No ☐ If YES, please provide details in the table below.

Name of specialist / professional	Contact address / telephone number	How often do you see them?

3) Do you receive support from anybody else such as friends or family?

Yes ☐ No ☐ If YES, please provide details in the table below.

Who provides support?	How do they support you?	How often?

4) Do you, or did you have, a statement of special educational needs? Yes ☐ No ☐

5) Do you, or did you, attend a special needs school? Yes ☐ No ☐

If YES, please provide address of school:

_____

_____

_____

_____

Section 4 – Drug, alcohol and substance misuse

1) Do you take any drugs that are not prescribed to you?

Yes ☐ No ☐ If NO, please go to Section 5. If YES, please advise:

a) what drugs you use

_____

_____

b) how often you use it / them e.g. daily, once a week

_____

_____

2) Do you drink alcohol regularly?

Yes ☐ No ☐ If YES, please advise:

a) how often you drink e.g. daily, once a week

_____

_____

b) what type of alcohol you drink e.g. spirits, beer

_____

_____

c) how much you drink e.g. one glass, two bottles

_____

_____

3) Do you currently receive any support for addictions you have? Yes ☐ No ☐

Yes ☐ No ☐ If YES, please provide details in the table overleaf.

Name of specialist / professional	Contact address / telephone number	How often do you see them?

If NO, would you like to be referred to an agency for support? Yes ☐ No ☐

4) Are you currently prescribed any medication for your addiction(s)? Yes ☐ No ☐

Medication	Dosage	Where do you get this medication from? e.g.GP prescription, hospital, chemist

5) Do you take the medication yourself or does someone else manage it for you?

☐ Take medication myself ☐ Medication managed by someone else (please provide details)

_____

_____

6) Have you previously had a drug/alcohol problem and are in recovery? Yes ☐ No ☐

If YES, please explain what addiction this was for and when your recovery started.

_____

_____

_____

Section 5 – Income benefits

1) Do you receive Disability Living Allowance (DLA)? Yes ☐ No ☐

If YES, please confirm what rates - high, medium or low

Care rate _____ Mobility rate _____

2) Do you receive Personal Independence Payment (PIP)? Yes ☐ No ☐

If YES, please confirm what rates – standard or enhanced

Daily living component _____ Mobility component _____

3) If you receive DLA, or PIP, how do you use the money to help you look after yourself?

_____

_____

_____

4) Do you receive Employment Support Allowance (ESA)? Yes ☐ No ☐

If YES, which group have you been placed in?

☐ Work Related Activity Group ☐ Support Group

5) Do you receive Attendance Allowance? Yes ☐ No ☐

If YES, please confirm what rate you receive ☐ High ☐ Low

6) Does someone claim Carers Allowance for you? Yes ☐ No ☐

If YES, please state their details below

Name _____ Relationship to you_____

Address _____

Details of care provided e.g. washing, cleaning _____

_____

Section 6 - Your current accommodation (where applicable)

1) Are you able to walk or use a wheelchair to get to the toilet? Yes ☐ No ☐

2) Are you able to get to the bathroom? Yes ☐ No ☐

3) Do you have any difficulty getting in/out of a bath? Yes ☐ No ☐

4) Do you have stairs to climb? Yes ☐ No ☐

If YES, can you climb them? (Please tick all that apply) ☐ Without Difficulty ☐ Manage with effort

☐ With 2 bannisters ☐ Unable to manage ☐ Stair lift installed?

5) Do you have steps to your doors? Yes ☐ No ☐

If YES, can you manage the steps? (Please tick all that apply)

☐ Without Difficulty ☐ Manage with effort ☐ With grab rails ☐ Unable to manage

6) Do you have any of the following adaptations to your home? Tick all that apply

☐ Ramp ☐ Level-Access shower ☐ Toilet downstairs

☐ Stair-Lift ☐ Through Floor Lift ☐ Shower (Over-bath)

☐ Door entry system ☐ Ceiling-track hoist

7) Please describe the heating in your home (please tick)

☐ Central Heating ☐ Warm Air Heating ☐ Individual Fires ☐ Gas ☐ Electric ☐ Solid Fuel

Other _____

8) Have you been awarded a Disabled Facilities Grant in the last 5 years? Yes ☐ No ☐

9) How are your health conditions made worse by your current home? (Please use additional sheets if necessary)

_____

_____

_____

10) Do you currently receive any help at home? Yes ☐ No ☐ If yes, please provide details

☐ Family _____

_____

☐ Home Care Services _____

_____

☐ Friend _____

_____

☐ Voluntary Services _____

_____

11) Do you require re-housing in order to accommodate a carer? Yes ☐ No ☐

12) Do you need any help with personal care such as washing yourself, getting dressed or bathing? Yes ☐ No ☐

13) Do you manage all your own housework? Yes ☐ No ☐

14) Do you manage to give yourself your own tablets or medicine? Yes ☐ No ☐

15) Do you suffer from falls? Yes ☐ No ☐

16) Do you have a personal alarm system e.g. Lifeline installed? Yes ☐ No ☐

If YES, what type of alarm? _____

If NO, would you like information on this? Yes ☐ No ☐

17) Would moving home improve your medical condition? Yes ☐ No ☐

18) IF YES, please provide details (Please use additional sheets if necessary)

_____

_____

_____

Section 7 – Declaration

To the best of my knowledge and belief, the information that has been provided on this form is true, complete and correct.

I give you my permission to obtain information from individuals or agencies referred to on this form in order to process my application. I authorise you to make any referrals necessary in connection with my application such as Occupational Therapists. I consent to any visits that may be needed to further assess my situation.

I understand it is an offence to give false or misleading information, or to hold back relevant information. I also understand that you will check this information and if any information is found to be false, I may be prosecuted and you may repossess my home. If I am prosecuted and found guilty, I understand that I could be ordered to pay a fine of up to £5000.

It is my duty to make sure that the information I have given to complete my application form is honest. Failure to do so could lead to the Council evicting me from any tenancy I obtain illegally, through deception and/or dishonesty. I will immediately declare any changes to the information I have provided while I am waiting to be offered accommodation.

I confirm that I have read, understand and agree to the terms laid out in this declaration.

Signed _____

Name _____ Date _____

If you have filled in this form for on behalf of the applicant, please sign below.

Signed _____ Name _____

Relationship to applicant _____ Date _____