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**Medical Form**

**DETAILS OF MAIN APPLICANT** SECTION 1

SURNAME

ADDRESS

PHONE NUMBER

FIRST NAMES DATE OF BIRTH

TENANT ID NUMBER

NOTE: Please complete this form for each person on your application who has a medical condition or disability that you wish to have considered in determining appropriate accommodation. If there is more than one person on your application with the same illness you need only complete one form but you must ensure that the name of each person is written clearly on this form in SECTION 2.

# DETAILS OF MAIN PERSON/S

SECTION 2

SURNAME FIRST NAMES DATE OF BIRTH

# DETAILS OF MEDICAL CONDITION OR DISABILITY SECTION 3

NATURE OF ILLNESS/DISABILITY (PLEASE DESCRIBE AS FULLY AS POSSIBLE)

HOW LONG HAS THIS PERSON HAD THEIR ILLNESS/DISABILTY? IS THE NATURE OF THE ILLNESS LIKELY TO CHANGE IN THE NEAR FUTURE?

IF YES - PLEASE GIVE DE TAILS

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| --- | --- | --- | --- |
| DOES THIS PERSON USE ANY OF THE FOLLOWING: | A WALKING STICK? | A WHEELCHAIR? | A WALKING FRAME? |
|  | **Y / N** | **Y / N** | **Y / N** |

WHAT TABLETS/MEDICINE OR OTHER TREATMENT IS THIS PERSON CURRENTLY RECIEVING?

DOES THIS PERSON GET ADDITIONAL SUPPORT AND/OR CARE TO LIVE INDEPENDENTLY? (Please give details)

DOES THIS PERSON RECEIVE ANY OF THE FOLLOWING SERVICES? (IF YES - PLEASE WRITE HOW OFTEN THEY HAPPEN)

HOME HELP

**YES NO**

MEALS ON WHEELS

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DISTRICT NURSE

CARER

BATH ATTENDANT

SOCIAL WORKER PLEASE GIVE NAME OF SOCIAL WORKER

HOW OFTEN DOES THIS PERSON VISIT THE GP? HOW OFTEN DO THEY SEE THE HOSPITAL SPECIALIST?

# DETAILS OF PRESENT ACCOMODATION

SECTION 4

**YES NO**

ARE THERE ANY STEPS INSIDE YOUR ACCOMODATION? IF YES, HOW MANY?

ARE THERE ANY STEPS UP TO YOUR FRONT DOOR?

IF YES, HOW MANY?

HOW MANY ROOMS ARE THERE IN YOUR PRESENT ACCOMODATION? (PLEASE WRITE THE NUMBER IN THE APPROPRIATE BOX)

BEDROOMS LIVING ROOMS KITCHEN BATHROOM WC

WHICH ROOMS IF ANY DO YOU SHARE?

DO YOU LIVE IN A HOUSE?

**YES NO**

IF NO WHICH FLOOR IS YOUR FRONT DOOR ON?

IS THERE A LIFT YOU CAN USE?

**YES NO**

WHAT KIND OF HEATING DO YOU HAVE IN YOUR CURRENT ACCOMODATION?

WHY DOES THIS PERSONS ILLNESS/DISABILITY MAKE THEIR PRESENT ACCOMODATION UNSUITABLE

# DETAILS OF ACCOMODATION REQUIREMENTS

SECTION 5

THERE ARE VERY FEW MEDICAL CONDITIONS WHICH MAKE A CERTAIN TYPE OF ACCOMODATION ESSENTIAL

WHAT TYPE OF ACCOMODATION DO YOU THINK THIS PERSON NEEDS? (please give details, eg. lift access, ground floor, central heating etc.)

WHAT AIDS OR ADAPTATIONS DOES THIS PERSON REQUIRE IN THE ACCOMODATION? (please give details, eg. wheelchair access etc.)

# ADDITIONAL INFORMATION

SECTION 6

PLEASE USE THIS SECTION TO ADD ANY ADDITIONAL INFORMATION OR COMMENTS THAT YOU FEEL ARE RELEVANT ADDITIONAL SHEETS MAY BE ADDED IF NECESSARY

# DETAILS OF DOCTORS

SECTION 7

TO FULLY CONSIDER YOUR APPLICATION IT MAY BE NECESSARY FOR THE COUNCIL’S MEDICAL ADVISOR OR OCCUPATIONAL THERAPIST TO CONTACT THIS PERSON’S GP OR HOSPITAL SPECIALIST. PLEASE, THEREFORE, PROVICE THEIR DETAILS BELOW:

GP DOCTORS NAME: ADDRESS:

HOSPITAL SPECIALIST: TEL NO:

SPECIALIST’S NAME:

HOSPITAL DEPT: HOSPITAL: ADDRESS:

HOSPITAL REGISTRASTION NUMBER:

HOSPITAL TELEPHONE NUMBER:

# DECLARATION/PERMISSION

I DECLARE THE DETAILS GIVEN ON THIS FORM ARE TRUE.

I GIVE PERMISSION FOR SW9 COMMUNITY HOUSING’S MEDICAL ADVISOR OR OCCUPATION THERAPIST TO CONTACT THE ABOVE DOCTOR(S) OR HOSPITAL FOR FURTHER INFORMATION ABOUT THE ILLNESS/DISABILITY.

IF I ASK TO BE CONSIDERED FOR HOUSING IN ANOTHER BOROUGH OR HOUSING ASSOCIATION, I GIVE THEM THE SAME PERMISSION

SIGNED (PERSON OR PARENT OR GUARDIAN)

DATE: / /

NOTE: if you already have a letter from your hospital or doctor about your condition, and you decide to enclose it with this form, it will be considered. You do not, however, have to enclose any supporting letter with this form for your application to be considered and SW9 Community Housing will not pay any charge made to you for the letter.