Caledonia Housing Association Ltd

Medical Assessment Form - Confidential

Application Reference:

N.B. A separate Medical Assessment form must be completed by each member of the household affected by illness.

Name:

Address:

Date of Birth: Age:

Tel No: Email:

Relationship to Applicant (if different) :

For Office Use Only			
Date received		Grade awarded	
Processed by		Letter Issued	

1. What is the name of your actual medical condition?

2. Please say, in your own words, what your health problems are:
(please use a separate sheet if necessary)

3. Is your condition temporary or permanent? If permanent can you supply written confirmation? Please give details:

4. Are you registered disabled? Yes: No:

5. Do you or will you use a wheelchair? Yes: No:

6. Do you require any special facilities or adaptations?

If yes, please give details:

7. Do you have any adaptations at present? Yes: ☐ No: ☐
If yes, please give details:

8. Can you manage stairs? Yes: ☐ No: ☐
If yes, how many can you manage comfortably?

9. Does your condition mean you need an extra bedroom? (e.g. for a carer)
If yes, please give details:

10. Do you have difficulty getting to shops and other local facilities? How far away if you are walking? If yes, please give details:

11. What type of property do you currently live in?

Size (How many bedrooms):

Type:

Level Access:

Type of Heating:

Bathroom on same floor:

12. Please describe how your present house is adversely affecting your health:
(Please note we do not award points for stress/depression,
neighbour disputes/anti-social behaviour or asthma (unless directly attributable
to the condition of your property))

13. Please state how a move would change your situation (this must be directly related to your condition) and what kind of house you would require:
(Please note we do not award points for stress/depression,
neighbour disputes/anti-social behaviour or asthma (unless directly attributable
to the condition of your property))

14. Please provide a discription of the location of your home (e.g. hilly, level etc):

Please give:

Doctor's Name: Tel.No:

Address:

Do you have an Occupational Therapist, Social Worker or Specialist?

Yes: ☐ No: ☐

If Yes, please give details, e.g. name, job title, place of work and telephone number:

DECLARATION:

I hereby give permission to Caledonia Housing Association Limited to ask my doctor/specialis
social worker, in confidence, for further information relating to the specific illness stated:

The information given in this form is, to the best of my knowledge, correct.

Signature: ..... **Date:** .....

Medical Priority Assessment Form:

Part A: Comments of Housing Manager (continue on separate sheet, if necessary)

1. Applicant's circumstances:

2. Employment Details (if any):

3. Regular medication (Please state name and dosage, where applicable)

4. Locality/neighbourhood (Please give details of how these affect the applicant's medical condition)

5. Main reason(s) for requesting medical priority
(Please tick all that apply)

Mobility problems □
Social/neighbourhood problems □
Psychiatric/mental health problems □
Additional care/support required □

Person to contact in event of query

Name: ..... Tel.No ..... Fax: .....

Signed: ..... Date: .....

Part B: Recommendations of Assessor

1. Medical Priority

Category A	□	Urgent - 50 points
Category B	□	Serious - 30 points
Category C	□	Significant - 10 points
Category D	□	Medical priority refused

2. Mobility Category

a. Requiring support/assistance	□
b. Independent with difficulty	□
c. Completely independent	□

3. Housing recommendation

a. Suitable for indoor wheelchair use	□
b. Access for outdoor wheelchair use	□
c. Few external stairs (6 maximum)	□
d. No internal stairs	□
e. No garden	□
f. Near relative/carer	□
g. Near amenities	□
h. Extra bedroom	□
i. Level site	□

j. Other .....

Signed: .....

Date: .....