REQUEST FOR MEDICAL PRIORITY

Confidential

Please note: the person applying for rehousing on medical grounds should complete this part. If the person is unable to complete the form for any reason, it should be completed on their behalf. Please contact the Association's Office if you need advice on completing the form.

A separate form must be completed for each person who is requesting medical priority for rehousing.

Applicant's Name ……………………………………………………………………………...

Address ………………………………………………………………………………………….

……………………………………………………….Post Code ………………………………

Date of Birth ……………………………..Telephone No. ………………………………….

Name of person completing the form (if different from above)……………………….

Name and address of your family doctor (GP)…………………………………………..

…………………………………………………………………………………………………

Are you receiving regular treatment from your GP? Yes ☐ No ☐
(Please tick √ appropriate box)

IF YES, PLEASE GIVE FULL DETAILS OF TREATMENT AND MEDICATION BEING RECEIVED.

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Please describe how your present accommodation is affecting your health

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Are you registered disabled? Yes ☐ No ☐
(Please tick √ appropriate box)

Are you registered blind? Yes ☐ No ☐
(Please tick √ appropriate box)

1. **Have you been admitted to hospital recently ?** Yes ☐ No ☐
   (Please tick √ appropriate box)

   If Yes, please give the following details:-

   approximate date of admission ………………………………………………………….

   approximate date of discharge …………………………………………………………..

   name of hospital …..………………………………………………………………………

   name of hospital doctor/consultant, if known ……………………………………………..

2. **Are you attending a hospital clinic or outpatients clinic?** Yes ☐ No ☐
   (Please tick √ appropriate box)

   If Yes, please give the name of the clinic attended ………………………………….

3. **Do you have any difficulty with walking?** Yes ☐ No ☐
   (Please tick √ appropriate box)

   If Yes, do you use any of these aids?

   walking stick ☐ zimmer frame ☐ crutches ☐ wheelchair ☐ other ☐

4. **Do you have any difficulty in climbing stairs?** Yes ☐ No ☐
   (Please tick √ appropriate box)

   How many stairs do you feel that you could manage?

   Please give the number of stairs here _______________

5. Household details

Please list all of the people to be housed with you, including yourself.

NAME	Date of birth	Relationship To Applicant

6. Your present accommodation

(Please enter the appropriate number or tick the boxes that apply to you)

a. Size of house? ☐ bedrooms ☐ bedrooms available to household

b. Type of house? ____

c. Type of heating ☐ gas ☐ electric ☐ solid fuel

☐ other – please state type _______________________

d. Do you have a bathroom on the same level as your main living area?

Yes ☐ No ☐

e. Does your house have internal stairs? Yes ☐ No ☐

f. Is there a level access to your house? Yes ☐ No ☐

If **No**, please state the number of stairs ______

Please give details of anything that causes access problems for you:

……………………………………………………………………………………………...

……………………………………………………………………………………………...

7. **Do you have a garden at present?** Yes ☐ No ☐

If Yes, is the garden - small ☐ medium ☐ large ☐

8. **What is the approximate distance from your house to -**

a. Local shops __________

b. Post Office __________

c. Public transport __________

9. **Please describe the location of your house**
(For example, on a level site, in a hilly area, easy access, difficult access)

____

____

10. **Please give the name(s) and address(es) of relative(s) or anyone who is ` providing you with regular care and support**

____

____

____

11. **What type of housing would suit your medical needs?**
(Please tick √ all types that you feel are suitable)

Single level ☐	Ground floor ☐	First floor ☐
Above 1st floor ☐	Flat with lift ☐	Sheltered ☐
Larger house ☐	Near all amenities ☐	With garden ☐
Without garden ☐	Smaller house ☐	Near carer(s) ☐
Suitable for wheelchair access ☐		

12. **Does your present house have a dampness problem that affects your health?**
(Please tick √ appropriate box) Yes ☐ No ☐

If **YES,** please give details:

……………………………………………………………………………………………

……………………………………………………………………………………………

13. **Aids and adaptations**

a. Have you been provided with any aids to daily living (e.g. handrails, bathing aids) or have any adaptations been carried out to your present house as a result of your medical needs? **Yes** ☐ **No** ☐
(Please tick √ appropriate box)

b. If Yes, please specify the type(s) …………………………………………………

……………………………………………………………………………………………

14. **Have you applied for medical priority for rehousing before? Yes ☐ No ☐**
(Please tick √ appropriate box)

If Yes, when did you apply? ______________________________________

15. **Is there anything else that you would like to add in support of your application?** (Please use the following space)

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16. **Data Protection Act**

I hereby give permission to the Medical Advisor acting for West Dunbartonshire Council to ask my family doctor (GP), my hospital doctor/ consultant, and any other agency(ies) with an interest in my health for further information.

I understand that this information will be treated in the strictest confidence and that it will only be used to assess my request for medical priority for rehousing.

Signed ………………………………………………

Date …………………………………………………

Medical Priority Assessment Form

Part A: Comments of Housing Officer (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)

   Mobilty 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 _____________________

Medical Priority Assessment Form

Part B: Recommendations of Independent Medical Advisor

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 ☐

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 …………………………………………………………..