

# Finding A Home Medical Assessment Form



**Finding A Home Application  
Reference number:**

**Main Applicant's Title:**

(Mr / Mrs / Miss / Ms / Other)

**Main Applicant's First name:**

**Main Applicant's Middle name:**

**Main Applicant's Last name:**

**Please Note:** The existence of a medical problem / ill health alone will not automatically give priority to an application. Priority will only be given when a change in accommodation is likely to significantly improve the medical problem / ill health.

Please complete any answers at the end of the form if there is not enough space.

## 1. Personal details of person with medical problem

**Title:**

Mr / Mrs / Miss / Ms / Other:

**Surname:**

**Forename:**

**Date of Birth:**

 /  / 

**Occupation:**

**Address:**

**Relationship to Applicant:**

Are you Registered Disabled?  Yes  No

## 2. Present accommodation

2.1 Type of Accommodation:

2.2 Does your house have any special adaptations? Such as (please tick):

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> Second Stair Rail    | <input type="checkbox"/> Garden Rail         | <input type="checkbox"/> Ramp      |
| <input type="checkbox"/> Bath Hoist           | <input type="checkbox"/> Bath Seat           | <input type="checkbox"/> Stairlift |
| <input type="checkbox"/> Toilet Rail          | <input type="checkbox"/> Level access Shower |                                    |
| <input type="checkbox"/> Other (please state) | <input type="text"/>                         |                                    |

2.3 What sort of heating does your house have?

## 3. Mobility restrictions (please tick)

- Are you fully mobile?
- Unable to walk at all?
- Confined to a wheelchair?
- Able to walk with an aid? (either a walking stick or frame)

## 4. Medical problems

- 4.1 Please list any medical problems that are affected by your present accommodation. How long you have had them and what medical treatment (if any) are you taking:

	Problem	How Long	Medicine/Treatment
1			
2			
3			

- 4.2 How is the problem(s) affected by your present accommodation?

- 4.3 What sort of accommodation would help with this problem(s) and how would it help?

## 5. Help from other people

- 5.1 Do you have regular help from anyone with your everyday activities?  
(Such as washing, dressing, cooking, cleaning)?  Yes  No

If Yes, please give details of how you are helped:

- 5.2 Do you have help from a support worker?  Yes  No

If Yes, please give details of the type of support you receive and how often:

## 6. Health Services

6.1 Name of Doctor:

Address of Surgery:

6.2 When did you last see your Doctor?

6.3 Name of Hospital Consultant (if any)

Hospital Attended:

6.4 Other Health Care Works (if any) involved with you  
e.g. Health Visitor, District Nurse, CPN etc.

Name:

Type of Health Care Worker:

Where they can be contacted:

