



LANARKSHIRE HOUSING ASSOCIATION

MEDICAL SELF ASSESSMENT FORM

CONFIDENTIAL

191 Brandon Street, Motherwell ML1 1RS ☎ 01698 269119

DETAILS

Name of Applicant _____

Address _____

Name of Person with medical condition (if different from above)

_____ Date of Birth _____

YOUR MEDICAL CONDITION/HEALTH PROBLEMS

Please use the space below to describe the nature of your problem(s). Please state how long you have experienced these difficulties:

YOUR MEDICAL CONDITION & YOUR CURRENT HOME

Please describe what aspects of your current home affect your medical condition and make your accommodation unsuitable:

MOBILITY PROBLEMS

Do you have any difficulty walking?

Yes

No

Some difficulty

Do you require any of these to help you get around?

Walking Stick	<input type="checkbox"/>
Walking Frame	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>

If you have a wheelchair, do you use it indoors or outdoors?

Both	<input type="checkbox"/>
Outdoors only	<input type="checkbox"/>

Do you have problems with stairs?

Yes No

If yes

Inside	<input type="checkbox"/>
Outside	<input type="checkbox"/>
Both	<input type="checkbox"/>

Please describe your difficulties, indicating how many stairs you can manage easily and if you currently use aids or adaptations to help you:

ENVIRONMENT

Do your mobility problems prevent you from using any rooms in your present home?

Yes No

If yes please give details:

Does your illness or disability cause you to need an extra bedroom?

Yes No

If yes please detail:

Do you have any difficulty getting to the shops and other facilities?

Yes No

If yes please give details:

OTHER HEALTH PROBLEMS

If your health problem is not covered by any of the questions above, please detail how your housing conditions affect your illness or disability:

MEDICAL TREATMENT/SUPPORT

What kind of treatment do you receive for your problem?

Are you taking any medicines? Yes No

If yes, please detail which (taking names from your containers):

REGISTERED DISABILITY

Are you registered disabled? Yes No

Are you registered blind? Yes No

DISABILITY BENEFITS

Do you receive any disability benefits? Yes No

If yes, which:

HOSPITAL

Have you been in hospital recently? Yes No

If yes,

Reason for admission _____ Date _____

Length of Stay _____

Date of Discharge _____

Name of hospital _____

Name of hospital doctor/consultant _____

CLINIC

Are you attending a clinic or other medical establishment?

Yes No

If yes,

Frequency _____

Address of Clinic _____

Name of hospital doctor/consultant _____

Please give details of your family doctor:

Name _____

Address _____

Phone No. _____

Do you get help from anyone else : Yes No If yes detail below:

	Name	Address	Phone No.
Relative			
Friend			
Social Worker			
Home Help			
Occupational Therapist			
Health Visitor			
District Nurse			
Voluntary Organisation			
Other			

STAYING IN YOUR HOME

Would you prefer to stay in your own home if you could?

Yes

No

ADAPTATIONS

Has your home been adapted in anyway because of your health or mobility difficulties?

Yes

No

If yes, please detail:

DECLARATION AND CONSENT

"The information detailed on this form by your GP will be used by Lanarkshire Housing Association to assess your entitlement to medical priority in the context of housing allocation. It will also be used to inform judgements as to what repairs, improvements or amendments may be required to the property that you occupy. Where, based on the information contained on this form, some action is to be taken to improve your housing circumstances then this may involve disclosing certain aspects of this information to third parties (such as providers of repair and maintenance services). We are also likely to use this information for statistical purposes and, generally, to assist in improving our service to you and maintaining our housing stock. We are also under a general obligation to protect public funds entrusted to us and so we may use the information to prevent or detect fraud. We are able to lawfully process information about your health condition for a number of reasons without consent but, to extend that reasons do not exist in relation to the above purposes, by providing this form to your GP for completion, you are indicating your explicit consent to the above."

Signed _____ Date _____

NOTES

Notes

- 1. Completing the form:** To help us assess your application for medical priority please answer all of the questions on this form. If you are unable to complete the form yourself, ask for help at the office, or seek help from a member of your family, a friend or carer.
- 2. Confidentiality:** Your replies are strictly confidential and only used to assess your medical priority for rehousing.
- 3. More than one person claiming medical priority?:** A separate form should be completed for each person for whom medical priority is claimed.
- 4. Returning your form:** Please return this form to the Association NOT your G.P.