WESTMINSTER CITY COUNCIL
Housing Options Service

MEDICAL ASSESSMENT FORM

Ref. No. ______________

Filling in this form:

Please complete this form if you have a medical/health condition that you would like us to consider as part of your application with us. **Separate forms** should be filled in for anyone in your household with a medical/health condition, who we have agreed is part of your application.

About the assessment:

We will carefully consider the information given to us and if necessary, it will be referred to our Medical Advisor for an opinion and/or recommendation. Taking in to account all of the relevant information we will then give a decision about the assessment, which includes if any medical priority can be given.

There is no requirement to obtain a medical report, letter or other supporting information from your Doctor, Consultant, Psychiatrist, or other health-care professional. If necessary, we will contact them directly. To do this, we require full completion of the declaration and authorisation on the last page of this form.

Notification of the outcome of this medical assessment will be put in writing, detailing how it affects your application.

Please complete in FULL, giving as much detail as possible. Failure to do so could result in a delay to your assessment.

If you already have supporting information e.g. medical letters, prescriptions, hospital discharge summary or medical reports please enclose copies with the form.

If you are going to see your GP before completing the form, please ask for a copy of your Patient Summary.

If you would like information on how to be more independent/safe in your own home or you or someone you know is a carer for a vulnerable person please visit www.peoplefirstinfo.org.uk for information on the help available and your rights under the Care Act 2014.

SECTION 1 DETAILS OF PERSON TO BE ASSESSED

Surname:……………………………... **First name(s)**:…………………………

☐ Male ☐ Female Date of birth:……/……/……..

Contact telephone number:………………………………….

Relationship to main applicant:…………………………………………………..

Current address: ……………………………………………………………………

…………………………………………………………**Post Code**:……………….

SECTION 2 YOUR CURRENT ACCOMMODATION

What type of accommodation do you have?

☐ Flat ☐ House ☐ Maisonette ☐ Hotel ☐ Hostel

☐ Other (please specify):………………………………………………………

If you have a council tenancy, are you a Westminster Council tenant?

☐ Yes ☐ No - Please state which Council:………………………………..

How many bedrooms do you have? ……..bedrooms

What floor is the entrance to your accommodation on? ……..floor

Are there any stairs inside your accommodation?

☐ No ☐ Yes - How many?……………stairs

Is there a lift? ☐ No ☐ Yes - **Does it go to your floor?** ☐ Yes ☐ No

If there is no lift, how many steps are there from the main entrance to your front door? ……..steps

Do you have use of your own kitchen and bathroom? ☐ Yes ☐ No
If no please state where they are located and who you share with:

……………………………………………………………………………………..

SECTION 3 MEDICAL DETAILS

Medical/health Condition(s):

1: …………………………………………………………………………………………

2: …………………………………………………………………………………………

3: …………………………………………………………………………………………

4: …………………………………………………………………………………………

5: …………………………………………………………………………………………

6: …………………………………………………………………………………………

7: …………………………………………………………………………………………

8: …………………………………………………………………………………………

What medication are you taking and what is it for?
(Attach copy of repeat prescription if you have one)

Medication (include dosage):	**For the treatment of?**
________________________	______________________________
________________________	______________________________
________________________	______________________________
________________________	______________________________
________________________	______________________________
________________________	______________________________
________________________	______________________________

Who is treating you (e.g. doctor, hospital consultant, other – please specify)?

……………………………………………………………………………………………..

……………………………………………………………………………………………..

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Are you waiting for an operation?

☐ No ☐ Yes - Please give details:

……………………………………………………………………………………………..

What is your NHS Hospital Number?..................................

Are you pregnant? ☐ No ☐ Yes - Expected date of delivery:…./……/……

Are there any pregnancy related complications? ☐ No ☐ Yes - Give details:

……………………………………………………………………………………………..

……………………………………………………………………………………………..

Are you registered blind?

☐ No ☐ Yes - Registration Number: ……………………..

Can you climb one flight of stairs (approx. 14 steps)? ☐ Yes ☐ No -

If no, how many stairs can you climb or give the reason why you cannot climb any:……………………………………………………………………………………..

……………………………………………………………………………………………..

Do you use a wheelchair? ☐ No ☐ Yes - please give details:

Inside and outside accommodation? ☐ Yes ☐ No – if no, give details of when you use it: ……………………………………………………………………...

……………………………………………………………………………………………..

Do you use a walking aid e.g. a walking stick? ☐ No ☐ Yes - Please give details:

……………………………………………………………………………………………..

……………………………………………………………………………………………..

Are you in receipt of Disability Living Allowance or a Personal Independence Payment? ☐ No ☐ Yes – Please give details e.g. award date(s) or enclose a copy of your entitlement/award letter:

……………………………………………………………………………………………..

Is your medical/health condition affected by your current accommodation or accommodation that we are offering you?

☐ No ☐ Yes - Please state how:

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SECTION 4 DETAILS OF ANY CARE RECEIVED OR GIVEN

CARE RECEIVED

Do you have a carer? ☐ No ☐ Yes If yes,

Who provides you with care?

Surname:……………………………….. **First name(s)**:…………………………

☐ Male ☐ Female Date of birth:……/……/……..

Relationship to you:…………………………………………………………………...

Carers Address: ……………………………………………………………………

……………………………………………………………….**Post Code**:……………

Contact telephone number:…………………………………

Explain the care that you receive:

…………………………………………………………………………………………..

…………………………………………………………………………………………..

Do you need care during the day? ☐ No ☐ Yes – Explain why:

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

…………………………………………………………………………………………..

Do you need care overnight? ☐ No ☐ Yes – Explain why:

…………………………………………………………………………………………..

…………………………………………………………………………………………..

Do you need help with activities of daily living for example, travelling, shopping, cooking, washing etc? ☐ No ☐ Yes - give details:

…………………………………………………………………………………………..

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Do you have a care package put in by a Mental Health or Social Services Team? ☐ No ☐ Yes - Please give details:

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…………………………………………………………………………………………..

CARE GIVEN

Do you provide care for anyone?

☐ No ☐ Yes If yes:

Person you provide care for: …………………………………………………

Relationship to you: ………………………………………………………..

Person's illness? …………………………………………………...

Actual care provided: ………………………………………………………...

………………………………………………………………………………….

Number of hours per week that care is given? ……… hours

Where is the care given e.g. address?…………………………………………..

…………………………………………………………………………………..

Is person in receipt of Carers Allowance? ☐ Yes ☐ No If no, please state why:

…………………………………………………………………………………..

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SECTION 5 DETAILS OF HEALTH CARE PROFESSIONALS

General Practitioner (GP/Doctor):

Title: ……. **Surname**:……………………………..

Name of surgery:…………………………………..

Address: ………………………………………………………………………………

…………………………………………………… **Postcode**: …………………

Telephone number:…………………… **Fax number**:………………….

Hospital Consultant:

Title: ……. **Surname**:……………………………..

Hospital name:…………………………… **Department/Clinic**:…………………

Address: ………………………………………………………………………………

……………………………………………………**Postcode**: …………………

Telephone number:…………………… **Fax number**:………………….

Hospital Consultant:

Title: ……. **Surname**:……………………………..

Hospital name:…………………………… **Department/Clinic**:…………………

Address: ………………………………………………………………………………

……………………………………………………**Postcode**: …………………

Telephone number:…………………… **Fax number**:………………….

Psychiatrist / Psychologist / Therapist:

Title: ……. **Surname**:……………………………..

Address: ……………………………………………………………………………

…………………………………………………………. **Postcode**: …………………

Telephone number:…………………… **Fax number**:………………….

Care Manager:

Title: ……. **Surname**:……………………………..

Address: ……………………………………………………………………………

…………………………………………………………. **Postcode**: …………………

Telephone number:…………………… **Fax number**:………………….

SECTION 6 ADDITIONAL INFORMATION

Please use this space if there is any other information you would like to provide that relates to your medical/health condition:

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SECTION 7 DECLARATION AND AUTHORISATION

Warning of criminal offences under the Housing Act 1996

It is an offence to give false or misleading statements, or to withhold information that is relevant to your application; you will be prosecuted if you do and, if convicted, receive a heavy fine.

Before assessing your application you must sign below to confirm that the information you have given on this form is true. By signing you are also agreeing to us seeking information about you from third parties and to using and sharing information about you with certain third parties.

Please ensure that you have read the Data Protection Act 1988 notice on your Application Form.

I agree to tell Westminster's Housing Options Service of any changes which affect the information I have given. I understand that if I have given false or inaccurate information or I do not tell the Housing Options Service of any relevant changes in my circumstances, the City Council may defer, cancel or amend my application. I also understand that if I am given accommodation as a result of false information given knowingly or recklessly, the landlord may take legal action to recover the property.

I also agree to allow my doctor/hospital consultant/psychiatrist/other health professional to give details about my medical condition(s) related to my application for rehousing to Westminster City Council's Medical Advisor.

Title: ……..	**Title**: ……..
Surname: ……………………………	**Surname**:………………………..
First name(s):……………………….	**First name(s)**:……………………
Signature:…………………………..	**Signature**: ………………………..
Date: …………………….	**Date**: …………………….

If you did not complete this form yourself, who filled it in for you?

Title:……… **Surname**:.......................…. **First name(s)**:……………

Relationship to you: ………………………………

Job title: …………………………… **Company/Organisation**: ………………

Completed form to be sent to:
Housing Options Service, 101 Orchardson Street, London, NW8 8EA