

Self Assessment Medical Form

Application no:

Only complete this form if your current accommodate is affecting your health or the health of a member of your household. Your household only consists of family members due to move with you.

The information that you give on this form will help the Councils medical panel assess your need for rehousing and you should supply any supporting documents from medical professionals that you think may be relevant. Please complete a separate form for each person in your household whose health is affected by your accommodation.

Your name	
-----------	--

Name of person to be assessed	
-------------------------------	--

Relationship to you	
---------------------	--

Their/your date of birth	
--------------------------	--

Address

Please provide the following information where it applies to you:

Doctor's name and address
Tel no

Consultant's name and address
Tel no

Social Workers Name
Tel no

Occupational Therapist's name
Tel no

Do you receive/have any of the following?

Home Care Yes No

Health Visitor Yes No

District Nurse Yes No

Floating Support Yes No

Do you receive any of the following?

Attendance Allowance Yes No

Please specify rate _____

DLA Care Allowance Yes No

Please specify rate _____

DLA Mobility Allowance Yes No

Please specify rate _____

Do you receive or need any assistance with your personal care?

Yes No

If yes, please give details:

Please give the medical diagnosis of your illness or disability (please supply evidence of this):

Please give the names of all the medication you are currently taking and please state the dosage:

Please tell us the history of your condition:

Please tell us if you have ever been admitted to hospital through your illness or disability and if so, the dates you were in hospital.

If you have **mobility difficulties**, how many steps do you have to negotiate to the front door?

Which floor do you live on?

Do you use any walking aids?

Yes No

If yes, please specify:

Do you need to use a wheelchair indoors?

Yes No

Do you need to use a wheelchair outside?

Yes No

Are you housebound?

Yes No

Do you currently have lift access to your home?

Yes No

Please use the space below to describe how **your present accommodation directly affects your illness or disability**. Please continue on a separate sheet of paper if necessary.

Declaration

Please read and sign the following statement

To the best of my knowledge the information I have given is correct. I understand that the medical panel will consider the information given when deciding any medical priority. I give permission for my doctor, consultant and other medical professionals involved in my case to be contacted by the medical panel if necessary.

Signed _____ Date _____

If this form has been completed by anyone other than the main applicant, please give details below.

Completed by _____ (print)

Signed _____

Relationship to main applicant _____

If you need any further advice, please contact:

Housing Options & Advice, Dartford Borough Council, Civic Centre, 1 Home Gardens,
Dartford, Kent, DA1 1DR Tel: 01322 343114

Office Use Only – Medical Panels comments