ISLINGTON

Islington Housing Services

Medical assessment form

Please read this form carefully before you fill it in

The medical assessment scheme is designed to identify the housing needs of applicants who are homeless or whose present accommodation is not helping their medical condition or disability.

Please make sure you fill in all the sections that apply to you. If you do not, we will return the form to you, as we will not be able to assess your case properly.

You should only fill this form if:

- Your disability or health problems are severe and permanent
- Your current home makes your disability or health problems worse; or
- Your current home is difficult to manage due to your disability or health.

Difficulties arising from overcrowding affect a very large number of households in Islington and additional medical priority will generally not be awarded for problems solely relating to overcrowded accommodation.

You must fill in a separate form for each member of the household who has difficulty managing in the home due to their disability or health problems.

Please do not fill in this form if your disability, health or housing problems are one or more of the following

- You are pregnant or have a problem with your current pregnancy that is likely to improve once you have had the baby.
- You have an illness or injury that is likely to get better with treatment, for example if you are recovering from surgery.
- Your housing problems are solely due to the state of disrepair in your home for example damp, condensation; lift breakdown, pest or rodent infestation. Contact your landlord or housing manager and discuss how to resolve these issues.
- Your housing problems are because of anti-social behaviour, neighbour problems. Contact your Landlord or housing manger and discuss how to resolve these issues.

Health Questionnaire

In answering these questions, please circle the one appropriate to you.

1. About you (the applicant):

Title: Mr Mrs Miss Ms Other (please state) Date of Birth: .....

Surname..... First name.....

Address.....

.....Postcode.....

Telephone..... Mobile.....

2. About the person with the health problems

Title: Mr Mrs Miss Ms Other (please state) Date of Birth: .....

Surname..... First Name.....

Telephone..... Mobile.....

Please state your relationship to the main applicant:.....

Are you working at present: Yes No

What is the nature of your work/profession? .....

Please list everyone you live with:

Name	Relationship	Age	Is part of your application Y/N

3. About where you currently live:

Are you currently: (tick box)

A council tenant		A housing association tenant	
A private tenant		Owner-occupier	
Homeless		Living with friends or family	

If your property is managed by a Housing Association,

Please give the name and telephone number of the association

.....

What type of property do you live in?

Bed-sit Flat Maisonette Bungalow House Hostel Other (please state)

How long have you lived at this address?.....

On what floor level is your home:.....

How many steps do you need to climb to get from street level to your front door? .....

How many steps do you need to climb inside your home: .....

Is there lift access to your flat? Yes / No

Please state how many lifts in your block? (please state): 1 2 3 4

Please state lift numbers (if known):

How many lifts stop at your floor? (please state):

Please state the number of steps you need to climb to get to your front door if you use the lift: .....

How many bedrooms are there in the property where you live:

How many persons live in the property:

How many bedrooms does your household have use of:.....

How many persons in your household who need to move with you:

How many toilets does your household have use of: .....

On what floor of your home is your toilet:.....

What form of heating do you have in your property: gas central heating/electric storage/solid fuel/other (please state)

Has your home been adapted to assist you with day-to-day living? Yes / No

If yes, please give details:

.....

.....

4. Tell us about your disability or health problems

Please state what your disability or health problems are including your medical diagnosis if you know it.

.....
.....
.....

Please state how your feel your disability or health problems make your present home difficult to live in

.....
.....
.....

Please state how long since you have had your disability or health problems.....

How often do you need to see your doctor for each condition?

Weekly	Monthly	Every 3 months	Occasionally	Never

Please give details of any prescribed medication you are currently taking for your condition:

Name of medication Dosage For what condition How often do you take it

.....
.....
.....
.....
.....
.....
.....
.....

If you are homeless does your disability or health problems prevent you from finding a place to live?
YES/NO/I am not homeless

If yes, please explain:

.....

Please give us the details of your GP:

Dr.....

Address.....
.

.....Postcode.....Telephone.....

Have you ever been admitted to hospital (for at least one night) as a direct result of your illness/disability?

If "Yes" Please give date of last admission: ..... Length of stay: .....

How many times have you been admitted over the last 12 months as a direct result of your illness/disability?:.....

Name of Hospital.....

What treatment were you having?

Are you awaiting any further treatment e.g. surgery to treat your condition?

If "Yes" please give us the date: .....

Do you have a diagnosed mental illness? Yes / No (if no please go to Section 5 of this form)

If yes please tell us about any problems you have living at your present accommodation because of your mental illness

.....

.....

Do you currently see a psychiatrist? Yes No

If yes please give details

Name of psychiatrist.....

Address.....

Telephone number.....

Please state how often are your appointments.....

Have you ever been admitted to hospital for your mental illness?

If yes please give details

Name of hospital.....

Date you were last admitted.....

Why were you admitted.....

How long did you have to stay in hospital? .....

Do you have regular clinic appointments because of your mental health problem? Yes/No

If yes please give details.....

Name of Hospital or Clinic.....

What treatment are you receiving?

How often do you attend?.....

Do you receive help regularly at home because of your mental health problem? Yes / No

If yes who help you:

What help or service do they provide for you?

.....

Do you receive help from Social Services, Community Mental Health Team or any other agencies?

If yes please state what support you do receive:.....

..... Telephone number of the organisation:.....

5. About your ability to get around and do things:

Are you able to climb stairs: Yes / No If yes how many: .....

Do you have difficulty walking up a flight of steps (a flight is usually 12-14 steps) Yes/No

If yes please state the amount of steps you can manage and the reason why you have difficulty managing more.

.....

.....

.....

Are you able to use a lift: .....If no please explain:

.....

How far can you walk on the level (please tick relevant box)

0		40-50 metres	
10-20 metres		50-100 metres	
20-30 metres			

Do you use any of the following :

Walking Stick Yes/No

Walking Frame Yes/No

Crutches Yes/No

Wheel Chair for outdoors only Yes/No

Wheel Chair for indoor and outdoor use Yes/No

Do you have difficulty getting on or off a bus by yourself Yes No?

If yes please state why it is difficult:.....

Are you able to get in and out of your bath?

Unable		With help	
With equipment		Independently	

Do you have any equipment or adaptation in your home that you use to help you because of your health/ disability?

Please explain

.....

.....

.....

6. Additional Information

Please give us any other information that you feel may be relevant to your application to be rehoused

.....
.....
.....

We may need to get more information from your GP of other health professionals

Please complete sign and date the authorisation form.

AUTHORISATION FOR MEDICAL INFORMATION

Doctor's Name: .....

Address: .....
.....
..... Tel: .....

Consultant's Name:.....

Hospital:.....

Address: .....
.....
..... Tel: .....

APPLICANT'S AUTHORISATION TO RELEASE MEDICAL INFORMATION

Applicant's Name: ..... Date of Birth:.....

Address: .....
.....
..... Tel: .....

Hospital Nos: .....

I give permission for the London Borough of Islington and its medical advisor to obtain further information from my GP and or any other health professional, mentioned on my medical assessment form.

Signed: ..... Date: .....

Parent/Guardian: .....

NB: Parent/Guardian must sign for persons under the age of 18 years.

ISLINGTON

If you would like this document in large print or Braille, audiotape or in another language, please contact 020 7527 2000.

Bengali
যদি আপনি এই তথ্য গুলো আপনার নিজ ভাষায় পেতে চান, তাহলে দয়া করে 020 7527 2000 নম্বরে যোগাযোগ করুন।

Chinese (Traditional)
如果你想要這資料的中文本, 請致電 020 7527 2000 聯繫。

Somali
Haddii aad jeclaan lahayd macluumaadkan oo ku qoran luqadaada fadlan la xidhiidh 020 7527 2000

Turkish
Buradaki bilgilerin Türkçesini istiyorsanız, lütfen 020 7527 2000 numaraya telefon edin.

Rehousing Team,
The Housing Aid Centre, 38 Devonia Road, London, N1 8UY
T 020 7527 4140 F 0207 527 4136 Minicom 0800 073 0536
E rehousing@islington.gov.uk W www.islington.gov.uk/housing

Printed on evironmentally friendly paper. Published July 2009.