MEDICAL NEEDS ASSESSMENT FORM

Guidance for completing this form

If you think that your current home is unsuitable due to your medical or mobility needs please complete this form.

You should complete all sections, providing as much information as you can. Ensure that you demonstrate how your medical condition would be improved by a move.

If you require any help or support in completing the form then please contact the Choice Move Team on 01246 217670.

This form is only valid if you have submitted a Housing Application Form.

Please DO NOT complete the form if any of the following apply;

- Your illness/injury is related to a pregnancy and will be resolved once the baby is born
- The illness/injury will get better with treatment (e.g. broken arm)
- You are in overcrowded accommodation – this will be assessed separately using information from your housing application
- You have a minor illness (e.g. cold, flu)
- Your property is in disrepair – if you are renting the property you will need to contact your current landlord and report these issues
- You have a temporary need for adapted accommodation (your illness/injury will improve with time/medication/medical support)

Once you have submitted this form it will be assessed by an Allocations Officer in the Choice Move Team.

If necessary, a referral will be made to the Rykneld Homes Occupational Therapist and they will arrange to visit you to assess your medical situation in your current home. You may be asked to display your capability to undertake certain household tasks, for example accessing your home, climbing the stairs or getting in and out of a bath.

Please be aware, the Occupational Therapist may not visit your home if you live outside of the North East Derbyshire District Council area.

You will need to provide a Patient Summary from your GP to support this application. Please provide any other supporting information you already have such as support letters or repeat prescriptions. This will all help us to determine your situation.

Office Use Only.	**Name:**	**Application Number:**

Section A - Personal Details

Please complete the details for the person applying for medical priority

First Name:

Last Name:

Date of Birth:

Address:

Contact Details:

Home phone: Mobile Phone:

Relative: Relative's name/relationship:

Height:

Weight:

Section B – Occupants of Present Accommodation

Please complete the details for any person living with you currently

Name	**Date of Birth**	**Gender**	**Relationship to applicant**	**Moving with applicant?**

Is the applicant currently in hospital? Yes ☐ No ☐

Please give details including the name of hospital, admission date, reason for admission and possible discharge date.

Section C – Your current accommodation

Please provide the following details for the property you currently live in

What type of property do you currently live in:

House ☐ Bedsit/Studio ☐ Hostel ☐

Bungalow ☐ Ground Floor Flat ☐ Caravan ☐

Upper Floor Flat ☐ Other ☐ (please specify) _____

How many bedrooms do you have?

How many steps are there inside your property?

How many steps are there outside your property?

Do you have a ramp or handrails to assist you? Yes ☐ No ☐

If yes, which adaptations do you have? _____

What parking facilities do you have?

Driveway/off road parking ☐ Communal Car Park ☐

On Street Parking ☐ Other ☐

Please describe_____

What bathing facilities do you have?

Bath ☐ Wet Room/level access shower ☐

Shower Over Bath ☐ Other ☐

Please describe _____

Shower cubicle ☐

Do you have difficulty using your current bathing facility?

Yes ☐ No ☐

If yes, please describe why

Do you have difficulty climbing stairs? Yes ☐ No ☐

If yes, how many steps can you easily manage?

Do you use any of the following to help you?

Walking stick/crutches ☐
Walking Frame ☐
Wheelchair ☐
Wheeled Walker ☐
Toilet frame ☐
Bath board/seat ☐

Do you have a lift in your property?

Stairlift ☐
Through floor ☐
Communal lift ☐

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

Indoors ☐ Outdoors ☐ Both ☐

Is the wheelchair self-purchased or a prescription? _____

What type of heating do you have in your current property?

Gas ☐ Solid Fuel ☐ Electric ☐ Other ☐

Please specify _____

Do you have problems with the heating in your home? Yes ☐ No ☐

If yes, please explain

Where do you currently sleep?

Upstairs ☐

Downstairs ☐

If downstairs, which room?

What toilet facilities do you have?

Upstairs WC ☐

Downstairs WC ☐

Outside WC ☐

What adaptations does your current home have?

Stairlift ☐ Ramp ☐ Ground Floor WC ☐

Wet Room ☐ Hand Rails ☐ Stair rails (how many) ☐

Other Please specify:

Do you use any other equipment to help you mobilise in your home?

Section D – Your Medical Needs

Please provide as much information as possible regarding your health

Please describe your medical conditions:

How does your current home affect your medical conditions?

What medication do you take for your medical condition?

Please give the name of medication, strength and how often it is taken.

Do you receive any of the following benefits for your ill health/disability?

Disability Living Allowance ☐ Carers Allowance ☐

Personal Independence Payment (PIP) ☐ Attendance Allowance ☐

Incapacity Benefit/ESA ☐ Statutory Sick Pay ☐

Can you carry out the following tasks unaided?

Cooking ☐ Shopping ☐ Dressing ☐

Cleaning ☐ Bathing ☐ Toileting ☐

If you cannot carry out any of these tasks, please give details of the help you currently receive or the help that you will need?

Do you have access to a car?

Yes ☐ No ☐

Do you have a blue badge

Yes ☐ No ☐

Do you have access to a mobility scooter?

Yes ☐ No ☐

Do you use public transport?

Yes ☐ No ☐

What distance are you able to walk?

Inside home only ☐ A very short distance outside ☐

A moderate distance outside ☐ More than ¼ mile outside ☐

Do you have any problems accessing local shops/services?

Yes ☐ No ☐ If yes, please describe:

Do you have difficulty walking up hill?

Yes ☐

No ☐

Do you have a warden service?

Yes ☐

No ☐

Have you had any falls recently?

Yes ☐ No ☐

If yes, when was your last fall and how did this affect your health?

What medical treatment did you receive?

Have you had, or are awaiting, a Social Care assessment?

Yes ☐ No ☐ If yes, please give details.

Please give any further details regarding your medical conditions and how this affects your daily life.

Section E – Your New Home

Please provide details on the type of accommodation that would suit your needs

What property type would best suit your needs?

Bungalow ☐ House ☐ Bedsit/Studio ☐

Ground Floor Flat ☐ Upper Floor Flat ☐

How many bedrooms do you need?

1 ☐ 2 ☐

3 ☐ 4+ ☐

If you require an extra bedroom please explain why

Do you have an overnight carer? Yes ☐ No ☐

If yes, please provide details of who provides the care, for how many nights per week and whether they are a sleeping or waking carer?

When did you start receiving overnight care?

How long do you expect the overnight care will be needed?

What adaptations do you feel you require in your new property, if any?

Stairlift ☐ Wet Room ☐ Wheelchair Access ☐

Ground Floor Accommodation ☐ Ground Floor Bathroom ☐

Ramped access ☐ Sheltered Accommodation ☐

Other ☐ please explain:

Section E – Your Doctor/Consultant

Please provide details of your current medical support

Doctors Name:

Surgery Address:

When did you last see your GP?

Do you receive any regular help from a district nurse or home help?

Yes ☐ No ☐

If yes, please provide details of their name, agency & support provided

Do you regularly attend a clinic or hospital? Yes ☐ No ☐

If yes, please provide details of which clinic/hospital, for which condition and how often you attend this?

Please provide any other details you think are relevant for your Medical Needs Assessment

Section F – Declaration

Please read and sign below to give your consent for us to process your medical form

I confirm that all the information given on this form is correct and complete to the best of my knowledge.

I give my permission for Rykneld Homes Ltd (RHL) to contact any relevant individual or organisation/agency to obtain information that may be relevant to my application, including information from my Doctor, Consultant or Social Services, if necessary. Please note that RHL will not be responsible for any charges incurred.

I give permission for the above information to be passed to Rykneld Homes' Housing Occupational Therapist.

Please note, the person applying for medical priority should sign this form unless;

- Under the age of 16 – in this case a parent or person with parental responsibility should sign for them
- The person signing has Power of Attorney for the applicant Please provide RHL with a copy of the Power of Attorney, if you have not already done so.

Signature:	Date:

Please ensure supporting medical evidence is provided with your application for medical priority, this must include a Patient Summary from your GP.

If anyone other than the applicant has completed and/or signed this form, please provide details below;

Name of person completing form:	
Relationship to applicant/Agency:	
Contact Number:	
Signature:	Date: