

Medical Form

If you, or a member of your household have a illness, disability or welfare issue which makes your current home unsuitable Gateway to Homechoice will assess your need to move in accordance with the priorities set out in the Allocations Policy.

Please do not ask a Doctor to complete this form. Please complete the form in black ink.

Applicant details

Name of applicant _____ Date of birth _____

Address & postcode _____

Telephone number _____ Mobile number _____

Email address _____

Details of person with a medical problem (if different from above)

Name: _____ Date of birth: _____

Height: _____ Weight: _____

Relationship to main applicant: _____

(Please note - You will be required to complete a new form for each household member with a medical complaint)

About your medical condition – Please complete all questions and where necessary use a separate sheet of paper to continue your answers

1. Please provide details of your condition/disability/mental illness

2. How long have you/your household member had this condition/complaint?

3. Please describe the history of your illness, such as hospital admissions, diagnosis, treatment etc

4. How does your current housing affect your condition/disability or mental illness?

5. Describe how these difficulties could be helped if you moved elsewhere:

Details of medication

Do you take medication prescribed by your doctor to treat your condition? Yes/No (please circle)

If yes, give name of medication, state the dosage and how often taken or provide details on a separate page

_____ dose and how often _____

Does the person with a medical problem have contact with any of the agencies in the table below?
If the answer is "yes" please give name and telephone number.

GP: Name Contact details Date last seen:	Home Carer: Name Contact details Date last seen:
Occupational therapist: Name Contact details Date last seen:	District Nurse: Name Contact details Date last seen:
Social worker: Name Contact details Date last seen:	Floating Support: Name Contact details Date last seen:
Community Mental health team: Name Contact details Date last seen:	Hospital consultant: Name Contact details Date last seen:

Meals on Wheels: Name Contact details Date last seen:	Other : Name Contact details Date last seen:
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Details of benefits received – please delete as applicable

(Please provide us with a copy of your benefit award letters)

Attendance allowance: High rate/Low rate

PIP/Disability living allowance – care component: High rate/Middle rate/Low rate

PIP/Disability living allowance – mobility component: High rate/Low rate

Incapacity benefit/Employment and Support Allowance: Yes/No

Equipment to assist disabled persons

Do you have or do you require any of the following in your home to assist with your medical condition? Please tick as appropriate.

	Have	Require	Do not require
NHS walking aid for outdoor use			
NHS walking aid for indoor use			
NHS wheelchair for outdoor use			
NHS wheelchair for indoor use			
Stair lift			
Through floor lift			
Level access shower/wet room/walk-in shower			
Over bath shower			
Ramp to either front or back door			
Equipment to help you get in and out of the bath			
Equipment to help you use the toilet			
Bariatric equipment			

Other equipment you have – please specify below:

Other equipment you require – please specify below:

Do you have a car? Yes/No (please circle)

Do you have a disabled badge? Yes/No (please circle)

Do you have a guide dog/hearing dog/assistance dog Yes/No (Please specify)

Do you have a garden? Yes/No (please circle)

About Your Home – Please complete all questions

Are you:-

Renting from a council	Renting from a housing association	
In lodgings, B & B or a hostel	Homeless	
Renting from a private landlord	Living with family friends	
In a residential care home	An owner occupier	

Do you live in a: House/Bungalow/Bedsit/Flat/Caravan/Mobile Home/boat (please circle)

Floor level of your accommodation: Ground / 1st / 2nd / 3rd / above (please circle)

If your accommodation is above 1st floor do you have a lift? Yes / No (please circle)

Number of bedrooms in the property _____

Do you have level access throughout the property? Yes/No

If no please explain _____

Stairs

Can you climb stairs: With assistance/Unaided (please circle)

Can you climb stairs: Easily/With some difficulty/With great difficulty/Not at all (please circle)

Can you climb: Internal stairs/External stairs/Both (please circle)

Do you have to climb external stairs to access your current property? Yes/No

Toilet

Please state the location(s) of your toilet(s) in your current home: _____

Are you able to access your toilet: Easily/With some difficulty/With great difficulty/Not at all (please circle)

If not at all, please explain the difficulty you have _____

Bathroom

Is your bathroom: Upstairs/Downstairs (please circle)

Are you able to access your bathroom? Yes/No (please circle)

Are you able to get into and out of your bath? Yes/No (please circle)

If no, please explain the difficulty you have _____

Care packages

Do you currently receive care from social services? Yes/No

If yes, please give details _____

Is this care 24 hours? Yes/No

Do you currently receive any housing support (e.g. help with managing your finances, developing independent living skills, setting up a home or tenancy). This support service is often called "floating support".

Yes No

If yes please give details _____

Please provide any additional information here _____

Declaration and authority to seek information

- I/we confirm that the details I/we have given are to the best of my knowledge true in every respect.
- I/we confirm my/our agreement to Gateway to Homechoice obtaining medical details from my doctor or specialist or any other agency mentioned on this form in connection with my/our application.
- I/we will notify Gateway to Homechoice of any changes in the details provided on the application form.
- Please see the [Gateway to Homechoice Privacy Policy](#) for details of how your personal sensitive data is stored, kept secure and how long it is retained for

Signed: _____

Date: _____

If not completed by the applicant, please state your relationship to the applicant(s):

Please return to our postal address: Gateway to Homechoice, East Suffolk Council, Riverside, 4 Canning Road, Lowestoft, NR33 0EQ.