WOMEN'S PIONEER HOUSING

Health/disability assessment form

Please read this information before you complete this form. You should only fill in the form if you have a serious medical condition or disability which is directly affected by your current home.

This form will be handed to an independent doctor who will consider the information you give here, along with any information given by your GP or hospital consultant. The doctor may get in touch with your doctor to check facts or get more details if they are needed.

Your medical condition alone will not determine how much priority your application will get. The main concern will be to what extent your current housing situation is making a severe and ongoing medical condition worse.

We will not normally assess medical priority for depression or stress if the main reason for this is that your home is overcrowded. We already take this into account when deciding how urgently a larger home is needed. However we might consider this if you are undergoing psychiatric treatment.

Please make sure you answer all the questions and sign and date the form on the last page. Please give us as much evidence as you can to back up your claim as this will help make sure it gets assessed quickly. We will not be able to look into your claim if you do not give us enough information.

1. Personal details

Name			
Address			
		Postcode	
Email			
Phone	home	work	mobile
Date of birth	d d m m y y		

2. Your current home

How many bedrooms does your home have?	☐☐
How many steps do you have to climb from the street to reach the front entrance of the building?	☐☐
How many steps do you have to climb to reach your front door once you are inside the building?	☐☐
Is there a lift you can use?	☐ Yes ☐ No
Why type of heating do you have? ☐ central heating ☐ storage heaters ☐ gas fire ☐ electric fire ☐ other *(please say)*	

3. Your health

Please give details of all your medical problems or difficulties.

Description of problem/ difficulty/condition	How does this affect you?	How long has it affected you?
Description of problem/ difficulty/condition	How does this affect you?	How long has it affected you?
Description of problem/ difficulty/condition	How does this affect you?	How long has it affected you?

3. Your health contd/...

Description of problem/ difficulty/condition	How does this affect you?	How long has it affected you?
Description of problem/ difficulty/condition	How does this affect you?	How long has it affected you?

Please list any medication you have been prescribed.

Please explain how your current home is directly making your health worse.

4. Your mobility

Do you have any difficulty walking indoors? ☐ Yes ☐ No ☐ A little

Do you use any of the following to help you walk indoors?

stick	crutches	frame
☐ Yes ☐ No ☐ A little	☐ Yes ☐ No ☐ A little	☐ Yes ☐ No ☐ A little

Do you have any difficulty walking outdoors? ☐ Yes ☐ No ☐ A little

Do you use any of the following to help you walk outdoors?

stick	crutches	frame
☐ Yes ☐ No ☐ A little	☐ Yes ☐ No ☐ A little	☐ Yes ☐ No ☐ A little

Do you use a wheelchair? ☐ Yes ☐ No ☐ Sometimes

Do you have any difficulty climbing stairs? ☐ Yes ☐ No

If you answered yes, how many stairs can you climb?

☐ None ☐ Up to six ☐ One flight ☐ More than one flight

Are you able to use a lift? ☐ Yes ☐ No

If you find it hard to use stairs and/or you cannot use a lift, please explain what the problems are and say what you have had done to treat them.

Do you have any difficulty using a bath, WC or kitchen? If so, what are they?

If you have had any aids or adaptations made to your current home to help you use a bath, the WC or the kitchen, please describe them.

5. Your support and care

Do you get any support or care you could not cope without, from relatives, friends or care professionals*? ☐ Yes ☐ No

** for example, a home help or district nurse*

If yes, please give their details. Please also give *(on page six)* the details of any other health professionals who help you, including the type of support or help you get from them.

Type of care given/their relationship to you	
Name	
Address	
	Postcode
Email	
Contact phone	
Type of care given/their relationship to you	
Name	
Address	
	Postcode
Email	
Contact phone	
Type of care given/their relationship to you	
Name	
Address	
	Postcode
Email	
Contact phone	
Your GP's name	
Address	
	Postcode
Email	
Contact phone	

5. Your support and care contd/...

Your hospital consultant's name	
Address	
	Postcode
Email	
Contact phone	
Your social worker's name	
Address	
	Postcode
Email	
Contact phone	
Other health professional's name/occupation	
Address	
	Postcode
Email	
Contact phone	

6. Your consent for medical information

Please read this, then sign and date it as indicated	
I am aware that Women's Pioneer may need to make further enquiries to check or verify facts needed to support my application for a transfer. I give my consent for Women's Pioneer, or its appointed agent, to ask for and get relevant medical or social information from any appropriate professionals it contacts. I understand that this information will only be used to help process the transfer I have asked for and that it will not be passed onto any third party without my permission.	
Name	
Address	
	Postcode
Signed	**Date** d d m m y y