

## MEDICAL ASSESSMENT FORM 2016-17

**PLEASE COMPLETE THIS FORM AND RETURN TO THE ADDRESS DETAILED ABOVE**

**SECTION A** – To be completed by the Student before forwarding to GP/Medical Practitioner

|                |       |
|----------------|-------|
| Student Name:  | _____ |
| Student ID No: | _____ |
| Telephone No:  | _____ |

To ensure that your accommodation application is processed efficiently, please make sure that a GP or other medical practitioner completes the mandatory sections **B**, **C** and **D**. Sections **E** and **F** are not mandatory sections and should only be completed if you feel they are relevant.

**SECTION B** – All information received helps identify the correct type of accommodation most suited to your patient's needs; please complete all relevant sections providing as much detail as possible.

Please confirm the named patient's medical condition using the following criteria and provide further supporting evidence in Sections **C** and **D**.

|  |  |
|--|--|
| <input type="checkbox"/> Visually impaired   | <input type="checkbox"/> Dyspraxia                             |
| <input type="checkbox"/> Wheelchair user or mobility difficulties                    | <input type="checkbox"/> Autistic spectrum/Asperger's syndrome |
| <input type="checkbox"/> Deaf or hard of hearing                                     | <input type="checkbox"/> Mental health issues                  |
| <input type="checkbox"/> An unseen disability eg diabetes, epilepsy, heart condition | <input type="checkbox"/> Multiple disabilities                 |
| <input type="checkbox"/> A condition not listed please state: _____                  |  |

Date of diagnosis: \_\_\_\_\_ Date of last consultation: \_\_\_\_\_

**SECTION C** – Which of the following do you consider **ESSENTIAL** for the patient to manage their medical condition in relation to their University accommodation?

|   |  |
|---|--|
| <input type="checkbox"/> En suite bathroom            | <input type="checkbox"/> Lift access                                 |
| <input type="checkbox"/> Washbasin in room            | <input type="checkbox"/> Close to university                         |
| <input type="checkbox"/> Ground floor room            | <input type="checkbox"/> Personal care support                       |
| <input type="checkbox"/> Self-contained accommodation | <input type="checkbox"/> Additional accommodation for support worker |
| <input type="checkbox"/> Fridge for medication        |  |

**SECTION D** - Please provide additional information that supports why your patient would benefit from the above:

**Would your patient find it useful to have any of the following aides or adaptations? Tick if required**

|   |                          |   |                          |   |                          |
|---|--------------------------|---|--------------------------|---|--------------------------|
| Level access bathroom                   | <input type="checkbox"/> | Motorised door opening                            | <input type="checkbox"/> | Induction loop                          | <input type="checkbox"/> |
| Shower chair                            | <input type="checkbox"/> | Wheelchair accessible                             | <input type="checkbox"/> | Flashing light fire alarm               | <input type="checkbox"/> |
| Grab rails                              | <input type="checkbox"/> | Motorised scooter user                            | <input type="checkbox"/> | Flashing doorbell                       | <input type="checkbox"/> |
| Clos-o-mat (WC)                         | <input type="checkbox"/> | Manual/tracking hoist                             | <input type="checkbox"/> | Vibrating pillow                        | <input type="checkbox"/> |
| Section profiling height adjustable bed | <input type="checkbox"/> | Altered kitchen facilities ie lower work surfaces | <input type="checkbox"/> | Fridge/freezer (for prescription foods) | <input type="checkbox"/> |
| Mini cool (for medication)              | <input type="checkbox"/> |   | <input type="checkbox"/> |   | <input type="checkbox"/> |

**MEDICAL PRACTICE OR DEPARTMENTAL STAMP, DATE AND NAME OF DOCTOR:**

**Name of Doctor:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**ADDITIONAL INFORMATION SHEET**

**(TO BE COMPLETED BY THE STUDENT)**



**SECTION E** - Please tell us about any medical/disability conditions:

**SECTION F** - How do you feel your medical/disability condition affects your accommodation requirements?

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Please return to:  
Accommodation & Hospitality Services, Newcastle University, King's Gate, Newcastle upon Tyne, NE1 7RU