

Self Assessment Medical Form

Ref no:

Only complete this form if your current accommodation is affecting your health or the health of a member of your household. Your household only consists of family members who will be moving with you.

The information you give on this form will help the Homemove medical officer assess your need for re-housing. There is no need to contact your doctor when completing the form. Please provide us with copies of your prescription, patient summary, etc. Please complete a separate form for each person in your household whose health is affected by your accommodation.

Your name

D.O.B.

Address

Please provide the following information where it applies to you

Doctor's name and address

Tel no

Consultant's name and address

Tel no

Social Worker's name

Tel no

Occupational Therapist's name

Tel no



Brighton & Hove
City Council

Do you use any of the following services?

Home Care **Yes** **No** Health Visitor **Yes** **No**
District Nurse **Yes** **No** CareLink **Yes** **No**

Do you receive any of the following?

Attendance Allowance **Yes** **No** Please specify rate _____
DLA Care Allowance **Yes** **No** Please specify rate _____
DLA Mobility Allowance **Yes** **No** Please specify rate _____

Do you receive or need any assistance with your personal care?

Yes **No** If yes, please give details:

Do you receive a formal package of care? **Yes** **No**

If yes, please state how many hours of care per week you receive

Please give the exact nature of your illness or disability:

Please give the names of the pills or tablets you are taking and include a copy of your prescription:

Please tell us how long you have you been ill and/or disabled:

If you have **mobility difficulties**, how many steps are there from the pavement to the front door?

Which floor do you live on?

Do you use any walking aids? **Yes** **No**

If yes, please specify:

Do you need to use a wheelchair? **Yes** **No**

Do you need to use your wheelchair indoors? **Yes** **No**

Do you need to use your wheelchair outside? **Yes** **No**

Are you housebound? **Yes** **No**

Do you currently have access to a lift? **Yes** **No**

Please use the space below to describe how your present accommodation affects your illness or disability. Please continue on a separate sheet of paper if necessary.

Declaration

Please read and sign the following statement

To the best of my knowledge the information I have given is correct. I understand that the medical officer will consider the information given when deciding any medical priority. I give permission for my doctor, consultant and other medical professionals involved in my care to be contacted by the medical officer if necessary.

Signed Date

If this form has been completed by anyone other than the main applicant, please give details below.

Completed by (print)

Signed

Relationship to main applicant

If you need any further advice, please contact:

**Homemove, 4th Floor
Bartholomew House
Bartholomew Square
Brighton, BN1 1JP
Tel: 01273 294400**

Office use only - medical officer's comments

Priority

- Nil
- Minor
- Major
- Severe & Immediate

Date