

Self Assessment Medical Form



Brighton & Hove
City Council

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 due to move with you.

The information you give on this form will help the council's medical advisor assess your need for rehousing. There is no need to contact your doctor when completing the form as the medical advisor will do this if necessary. 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

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:

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 are from the pavement to the front door?

Which floor 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 advisor 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 advisor 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 293130

Office Use Only - Medical Advisor's comments

Priority

Low

Medium

High

Very high

Over-riding

Date