

PERTH & KINROSS COMMON HOUSING REGISTER
Self-Assessment Form – Medical Need
Private and Confidential

The Council takes ill health and disability into account when deciding who is in greatest need for a house. Please complete this form if you think that your health, or the health of someone you live with, is affected by where you live. Priority indicates the extent to which your current housing circumstances are adversely affecting your health. Priority is not automatically awarded because of your medical condition, nor does it indicate the severity of your medical condition.

Please fill in a separate form for each person whose health or development is being affected. The information will be treated in confidence. It will only be used to assess what help the Council can give you with housing.

Our Needs Assessment Officers will consider all the information you provide. We may also need to contact your GP but will only do this with your permission. If you give us this permission now it means there will not be a delay in considering your application. If you are willing to give consent for us to contact your GP about the medical information you provide in this form please sign both sections on the last page

Name of person needing medical assessment:

Date of Birth: _____

Address: _____

_____ **Post Code:** _____

Contact telephone number: _____

Under the terms of the Data Protection Act 1998 you have the right to access to your personal information, and where appropriate to have them corrected or deleted. In order to protect public funds, we may use information provided on this form to prevent and detect fraud. We may also share this information with other public bodies administering funds solely for this purpose. We are registered with the Office of the Information Commissioner and comply with all Data Protection principles in relation to the personal data we hold.

You can apply for access to the personal information the Council holds about you on payment of a fee of £10. Application should be made to the Executive Director (Housing & Community Care), Perth & Kinross Council, 2 High Street, Perth PH1 5PH.

1 Please describe your current relevant medical problems and indicate how severe they are and what you have been told about whether this will improve, worsen or stay the same. (Please use extra pages if you need to.)

Medical Condition(s):	
When did this start:	
Treatment	

2. Please briefly describe how your current home affects your condition(s):

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3. Do you have special needs due to: (Please tick each one that applies and provide any additional comments – you can use add extra pages if you need to.)

	Yes	Comments
Disability?		
Sensory impairment?		
Are you registered disabled/blind/partially sighted?*		If so, since when?
Delete as appropriate		
Mental illness/ mental health problems?		
Are you/have you been in hospital under a section of Mental Health Act?		If so, when?
Drug and alcohol addiction?		
Learning disability?		
Brain injury?		

Stroke?		
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4. Mobility (please tick and add any comments)

	Yes	Comments
Do you need to use a wheelchair indoors?		
Do you need to use a wheelchair outdoors?		
Do you need to use a wheelchair all the time?		
Do you need to use a wheelchair occasionally?		
Do you use any other mobility equipment? (Walking stick, walking frame, electric scooter – please specify what is used)		

Do you have any difficulties with walking? (please tick one box only and add any comments)

		Comments:
I do not have a difficulty walking		
I have a slight difficulty walking		
It is difficult for me to walk		
I cannot walk at all		

Do you have any difficulties with walking up and/ or down stairs? (please tick one box only and add any comments)

		Comments:
I do not have a difficulty with stairs		
I have a slight difficulty with stairs		
Stairs are difficult for me		
I cannot walk up/down stairs		

On an average day, how many steps on a stair can you manage?

How many steps are there to the front door where you live now?

Is your accommodation all on one level?	Yes			No	

If no, are there any steps up or down to:

1. the toilet – how		2. the kitchen –		3. Other – how	
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many?		how many?		many?	
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5.

Do you have any problems using a lift due to your medical condition? Supporting information is usually required.	
Yes	Comments:

6. Do you received Disability Living Allowance

Yes No At what level? _____

7. Do you have any problems with heights due to your medical condition?

Yes No

Comments:

8. For us to assess how your medical condition affects your daily life, please tick the columns and write any supporting information, where:

0 = no difficulties; 1 = slight difficulties;
2 = can manage with support/adaptations; 3 = cannot do

Daily Activities	0	1	2	3	Comments:
Going outside					
Using public transport					
Shopping					
Managing family responsibilities					
Handling bank/finance/benefits					
Doing housework (laundry, cooking, cleaning)					
Using kitchen and preparing meals					
Getting into and using the bath/ shower					
Getting to and using the toilet					
Getting into and using the lift					

9. If you have a physical disability would any repairs or adaptations to your home make it suitable for you to remain there? For example bathroom aids, wheelchair ramps, heating, shower, stair rail, stair lift etc.

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10. Do you drive a car? (Please tick appropriate box) Yes No

11. Do you have access to a car? (Please tick appropriate box)

Yes - regularly	
Yes - occasionally	
No	

12. Details of your GP and/or Hospital Doctor

GP's name:	
Address of surgery:	
Surgery telephone number:	

Hospital	
Which hospital:	
Which department:	
Doctor's name:	
Date of last visit:	
Date of discharge:	

Please add extra pages if you need to:

13. If you are receiving support services, please detail below

Support Services	Contact Name	Address/Telephone	How often do you see them?
Community Psychiatric Nurse			
District Nurse			
Health Visitor			

Support Services	Contact Name	Address/Telephone	How often do you see them?
Physio/Occupational Therapist			
Social Worker			
Teacher			
Day Centre			
Home care Worker			
Psychiatrist			
Welfare Officer			
Counsellor			
Relative/Carer			
Psychologist			

14. Do you have a Care-Plan? (Please tick) Yes No

Care Plan Co-ordinator's name:	
Care Plan Co-ordinator's address:	

15. Please explain how re-housing will help improve your health:

I declare that the information given here is true to the best of my knowledge. I also understand that if I have deliberately made a false or misleading statement, legal action could be taken against me.

Name:
(Please print your full name)

Address:

Signature

Date:

I hereby give consent for my GP/hospital or other health worker to release information to the Council's Social Housing Access Team and/or Housing Needs Assessment Panel.

Signature

Date:

If you are completing this form on behalf of someone, please give your details below:

Name:

Mr/Mrs/Miss/Ms/Dr:

Relationship to applicant:

Signature:

Date: