



A Scottish Charity: Charity No: SC 033962

MEDICAL SELF-ASSESSMENT FORM GUIDANCE

1. The key principle of assessing for medical points is that the medical condition itself will not be assessed, but whether rehousing can significantly alleviate the condition.
2. Once you return the form to the office, we will make a decision on whether it should be sent to our appointed independent medical advisor.
3. Only one member of a household can be awarded medical points. If more than one person has a medical condition, please complete a form for each one and the person who is likely to have the highest points awarded will be assessed.
4. The independent medical advisor will award points as follows:

Category A	Urgent medical priority	20 points
Category B	Serious medical priority	10 points
Category C	Significant medical priority	5 points
Category D	Medical priority refused	0 points
5. Please complete the medical form as thoroughly as possible so that the independent medical advisor can assess points as accurately as possible.
6. Ensure that you give your telephone number so that we can contact you for further information if we need to.
7. Please give the full address of your doctor as the independent medical advisor may wish to contact him/her.
8. If you are taking medication, please include the name of the medicine, the dose and the frequency you have to take it.
9. We will contact you after the independent medical advisor has assessed your application. We will tell you how many medical points you have been awarded and how many points in total you have. This will be approximately 3 weeks after you have returned your medical self-assessment form to us.

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CLYDEBANK HOUSING ASSOCIATION

REQUEST FOR MEDICAL PRIORITY

Confidential

Please note: the person applying for rehousing on medical grounds should complete this part. If the person is unable to complete the form for any reason, it should be completed on their behalf. Please contact your local housing office if you need advice on completing the form.

A separate form must be completed for each person who is requesting medical priority for rehousing.

Applicant's Name

Address.....

.....**Postcode**.....

Date of Birth **Telephone No.**

Name of person completing the form (if different from above).....

.....

Name and address of your family doctor (GP)

.....

Are you receiving regular treatment from your GP? Yes No
(Please tick appropriate box)

If Yes, please give brief details of treatment, medication, and the name of your medical condition.

.....

.....

Please describe how your present accommodation is affecting your health.

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.....

.....

1. **Are you registered disabled?** Yes No
(Please tick appropriate box)

Are you registered blind? Yes No
(Please tick appropriate box)

Have you been admitted to hospital recently? Yes No
(Please tick appropriate box)

If Yes, please give the following details: -

approximate date of admission

approximate date of discharge

name of hospital

name of hospital/doctor/consultant, if known

2. **Are you attending a hospital or outpatients clinic?** Yes No
(Please tick appropriate box)

If Yes, please give the name of the clinic attended

.....

3. **Do you have any difficulty with walking?** Yes No
(Please tick appropriate box)

If Yes, do you use any of these aids?
(Please tick appropriate box)

walking stick zimmer frame crutches wheelchair

other

4. **Do you have any difficulty in climbing stairs?** Yes No
(Please tick appropriate box)

How many stairs do you feel that you could manage? _____

Please give the number of stairs in your current home _____

5. Household details

Please list all of the people to be housed with you, including yourself.

Name	Date of Birth	Relationship to Applicant
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6. Your present accommodation

(Please enter the appropriate number or tick the boxes that apply to you)

a. Size of house? bedrooms

bedrooms available to household

b. Type of house? _____

c. Type of heating? gas electric solid fuel

other – please state type _____

d. Do you have a bathroom on the same level as your main living-area?

Yes No

e. Does your house have internal stairs? Yes No

f. Is there a level access to your house? Yes No

If No, please state the number of stairs?

Please give details of anything that causes access problems for you.

7. Do you have a garden at present? Yes No

If Yes, is the garden – small medium large

8. What is the approximate distance from your house to –

a. Local shops _____

b. Post Office _____

c. Public Transport _____

9. Please describe the location of your house

(For example, on a level site, in a hilly area, easy access, difficult access)

10. Please give the name(s) and address(es) of relatives or anyone who is providing you with regular care and support

11. What type of housing would suit your medical needs?

(Please tick appropriate box)

Single Level Ground Floor First Floor

Above 1st Floor Flat with lift Sheltered

Larger house Near all amenities With garden

Without garden Smaller house Near carer(s)

Suitable for wheelchair access

12. Does your present house have a dampness problem that affects your health?

(Please tick appropriate box)

Yes

No

If Yes, please give details

13. Aids and adaptations

a. Have you been provided with any aids to daily living (e.g. handrails, bathing aids) or have any adaptations been carried out to your present house as a result of your medical needs?

(Please tick appropriate box)

Yes

No

b. If Yes, please specify the type(s) _____

14. Have you applied for medical priority for rehousing before?

(Please tick appropriate box)

Yes

No

If Yes, where and when did you apply? _____

15. Is there anything else that you would like to add in support of your application? (Please use the following space)

16. If aids or adaptations could be provided to help you, would you prefer to stay in your own home?

(Please tick appropriate box)

Yes

No

17. Data Protection Act

I hereby give my permission to the Medical Advisor acting for Clydebank Housing Association to ask my family doctor (GP), my hospital doctor/consultant, and any other agency(ies) with an interest in my health for further information.

I understand that this information will be treated in the strictest confidence and that it will only be used to assess my request for medical priority for rehousing.

I also give my permission for the Housing Management Staff of Clydebank Housing Association to approach West Dunbartonshire Council in relation to medical points they have awarded me.

Signed _____

Date _____

CLYDEBANK HOUSING ASSOCIATION

Medical Priority Assessment Form

Part A: Comments of Housing Management staff (continue on a separate sheet, if necessary)

5. Main reason(s) for requesting medical priority
(Please tick all that apply)

Mobility problems

Social/neighbourhood problems

Psychiatric/mental health problems

Additional care/support required

Person to contact in event of query

Name _____ **Tel. No.** _____ **Fax** _____

Signed _____ **Date** _____

Medical Priority Assessment Form

Part B: Recommendations of Association's Medical Advisor

1. Medical Priority

- Category A Urgent – 20 points
- Category B Serious – 10 points
- Category C Significant – 5 points
- Category D Medical priority refused

2. Mobility Category

- a. Requiring support/assistance
- b. Independent with difficulty
- c. Completely independent

3. Housing recommendation

- a. Suitable for indoor wheelchair use
- b. Access for outdoor wheelchair use
- c. Few external stairs (6 maximum)
- d. No internal stairs
- e. No garden
- f. Near relative carer
- g. Near amenities
- h. Extra bedroom
- i. Level site
- j. Other _____

Signed _____

Date _____