



<b><u>Official Use only</u></b>
REF. NO.: .....
DATE STAMP:

# North Devon Housing Register Medical Questionnaire

The council's medical advisor will assess this form. Please complete it in as much detail as possible.

The purpose of this form is to determine what effect your current accommodation is having on your medical condition. Points will only be awarded if it is proven that there is a connection. Points are banded on need:

**0 = None    5 - 10 = Low    10 - 15 = Medium    15 - 20 = High    30 = Urgent**

Only complete this form if a member of your household suffers from long standing ill health or a disability that makes living in your current accommodation more difficult. A separate form must be completed for each member of the household who has long standing ill health or disability. If under 18 the form should be completed by a parent or guardian.

Send your completed form to:

**NORTH DEVON DISTRICT COUNCIL, HOUSING ADVICE CENTRE,  
25 BOUTPORT STREET, BARNSTAPLE EX31 1RP.**

## Section A - Applicant Details

1. Personal Details			
this must be the person who has the medical condition and/or disability			
Title	Mr / Mrs / Miss / Ms / Other:		
First name(s)			
Surname			
Former Name(s)			
Sex			
Marital Status			
Date of Birth		Age:	

2. Present Address	
Postcode	
Contact Telephone/Mobile No:	

## Section B - Details of Illness/Disability

<b>What is your illness or disability?</b>	
<b>Medication and dosage</b>	
<b>If you have difficulty walking</b>	
How far can you walk on level surface before feeling severe discomfort?	
How far can you walk up hills and stairs without feeling severe discomfort?	
Do you use a walking Aid?	<b>YES / NO</b>
If <b>YES</b> What do you use?	
<b>STICK:</b>	<b>FRAME:</b>
<b>OTHER:</b>	
Do you use a wheelchair outside or inside the home?	<b>YES / NO</b>
Do you receive the mobility component of Disability Living Allowance?	<b>YES / NO</b>
If <b>YES</b> - when was it granted and at what rate?	

## Section C –Your Current Home

<b>Details of your current home</b>	
Do you own your home?	<b>YES / NO</b>
Number of bedrooms:	
ONE <input type="checkbox"/>	TWO <input type="checkbox"/>
THREE <input type="checkbox"/>	FOUR <input type="checkbox"/>
MORE? ..... (Give number)	
Is your home a:	
HOUSE <input type="checkbox"/>	BUNGALOW <input type="checkbox"/>
BEDSIT <input type="checkbox"/>	FLAT <input type="checkbox"/>
MAISONETTE <input type="checkbox"/>	OTHER: ..... (Please describe)
Is it:	
GROUND FLOOR <input type="checkbox"/>	FIRST FLOOR <input type="checkbox"/>
SECOND FLOOR <input type="checkbox"/>	THIRD FLOOR <input type="checkbox"/>
FOURTH FLOOR <input type="checkbox"/>	ABOVE FOURTH FLOOR
Is there a lift?	<b>YES / NO</b>
How many steps are there to your property?	
Are the steps in a single flight?	<b>YES / NO</b>
If <b>NO</b> how many flights are there?	
Is there a steep hill or slope up to your property?	<b>YES / NO</b>
If there are steps or stairs <b>inside</b> your home how many?	

Are the steps in a single flight?	YES / NO
If <b>NO</b> how many flights are there?	
Does your property have? <b>BATH</b> <input type="checkbox"/> <b>SHOWER</b> <input type="checkbox"/> <b>BOTH</b> <input type="checkbox"/>	
Has your home any disabled adaptations?	YES / NO
If <b>YES</b> please give details	
Does your home have central heating?	YES / NO
How far is it to the nearest shops?	
How far is it to the nearest bus route?	
If you drive a car where do you park it?	
Does your property have an enclosed garden/play area?	YES / NO
<b>Given your medical or disability needs, what do you think is wrong with your current property?</b>	

## Section D – Care & Support Needs

<b>If you have care/support needs as a result of your health</b>	
Who do you receive care/support from?	
What care/support do you actually get? <b>DAILY VISITS</b> <input type="checkbox"/> <b>WEEKLY VISIT</b> <input type="checkbox"/> <b>LIVE IN CARE</b> <input type="checkbox"/> <b>OTHER</b> <input type="checkbox"/>	
What is done to help you?	
How long has this been necessary?	
Do you receive the care component of Disability Living Allowance?	YES / NO
If <b>YES</b> : When was it granted and at what rate?	Date: Rate:

Do you receive Attendance Allowance?	<b>YES / NO</b>
If <b>YES</b> : When was it granted and at what rate?	Date:  Rate:

<b>Please provide details of any GP/Hospital/Counselling Service that you have contact with</b>	
How often do you go?	
What is the purpose of your visit?	

<b>Your current housing position</b>	
Threatened with homelessness	
Other (please give details)	
Awaiting transfer	

<b>What sort of property would you like?</b>

<b>Why do you think this will be better for you?</b>

<b>DECLARATION</b>			
The above statement of health is true to the best of my knowledge. I understand that this information will be used by the Council's medical adviser to decide whether medical points should be given to my application for a move to alternative accommodation.			
I consent to my doctor giving information about my health in confidence to the Council's medical adviser.			
<b>Signed:</b>		<b>Date:</b>	

**FOR OFFICE USE ONLY**

COMMENTS:	
MEDICAL BANDING AWARDED:	
SIGNED:	DATE: