Official Use only
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 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

What is your illness or disability?
Medication and dosage
If you have difficulty walking
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? **Yes** ☐ **No** ☐

If **YES** What do you use?

Stick: ☐ **Frame:** ☐ **Other** (specify)**:** ☐

Do you use a wheelchair outside or inside the home? **Yes** ☐ **No** ☐

Do you receive the mobility component of Disability Living Allowance? **Yes** ☐ **No** ☐

If YES - when was it granted and at what rate?

Section C –Your Current Home

Details of your current home

Do you own your home? **Yes** ☐ **No** ☐

Number of bedrooms:

One ☐ **Two** ☐ **Three** ☐

Four ☐ **More** (Give number) ☐

Is your home a:

House ☐ **Bungalow** ☐ **Bedsit** ☐

Flat ☐ **Maisonette** ☐ **OTHER (Please describe):** ☐

Is it:

Ground Floor ☐ **First Floor** ☐ **Second Floor** ☐

Third Floor ☐ **Fourth Floor** ☐ **Above Fourth Floor** ☐

Is there a lift? **YES** ☐ **NO** ☐

How many steps are there to your property? ☐

Are the steps in a single flight? **YES** ☐ **NO** ☐

If **NO** how many flights are there? ☐

Is there a steep hill or slope up to your property? **YES** ☐ **NO** ☐

If there are steps or stairs **inside** your home how many? ☐

Does your property have?

Bath ☐ **Shower** ☐ **Both** ☐

Has your home any disabled adaptations? **YES** ☐ **NO** ☐

If **YES** 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** ☐

Given your medical or disability needs, what do you think is wrong with your current property?

Section D – Care & Support Needs

If you have care/support needs as a result of your health
Who do you receive care/support from?

What care/support do you actually get?

Daily visits ☐ **Weekly visit** ☐

Live in care ☐ **Other** ☐

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 **YES:** When was it granted and at what rate?	Date:
	Rate:

Do you receive Attendance Allowance? **YES** ☐ **NO** ☐

If **YES:** When was it granted and at what rate?	Date:
	Rate:

Please provide details of any GP/Hospital/Counselling Service that you have contact with	
How often do you go?	
What is the purpose of your visit?	
Your current housing position	
Threatened with homelessness	
Other (please give details)	
Awaiting transfer	
What sort of property would you like?	
Why do you think this will be better for you?	

DECLARATION

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.

Signed:		**Date:**	

FOR OFFICE USE ONLY

COMMENTS:	
MEDICAL BANDING AWARDED:	
SIGNED:	DATE: