Havering
LONDON BOROUGH

HOMES & HOUSING
Housing Options Service
CONFIDENTIAL

Medical / Disability Questionnaire FOR EXTRA CARE

If you do not wish to complete the questionnaire or if you have difficulty answering the questions, please telephone: 01708 434130 or email: housingneeds@havering.gov.uk
Please return the completed form to: Needs & Service Development Team, Homes & Housing, 5th floor Mercury House, Mercury Gardens, Romford RM1 3SL.

Please write clearly and tick the correct box ☑

If there is more than one person in the household who needs to be assessed, please complete a separate form for each person

PLEASE NOTE: Sending us details of the same medical condition more than once will not improve the prospects of the Council meeting your requirements.

Section 1 – Person needing medical assessment

Name (of affected person)..... Date of Birth .....

Relationship to housing applicant .....
(e.g. wife, husband, son, daughter etc.,)

Address .....

.....

Contact Telephone Numbers:

Home ..... Work ..... Mobile .....

Please give details of people that will be living with you:

Name ..... Date of Birth .....

Name ..... Date of Birth .....

Name ..... Date of Birth .....

Name ..... Date of Birth .....

Section 2 – Details of your present accommodation

Please tick boxes as appropriate

Do you live in a:	House	☐	Maisonette	☐	No home	☐
	Flat with lift	☐	Flat without lift	☐	mobile home	☐
	Bungalow	☐	Ground floor flat	☐	caravan	☐

What is the floor level of your front door? ……..

Is the stair case internal or external (delete as appropriate)

Is there a lift? Yes ☐ No ☐

BEDROOMS AND OTHER ROOMS OCCUPIED

Bed.1	Full Names	Ages	Relationship of person to you
Bed.2	Full Names		
Bed.3	Full Names		
Bed.4	Full Names		
Bed.5	Full Names		
Living Room	Full Names		
Dining Room	Full Names		
Loft/Attic conversion	Full Names		

Section 3 - Details of ill health or disability

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How long have you had this condition? ……...

3a. Has your property been adapted? i.e. (level access shower, ramps, hand-rails, raised toilet seat, stair lift, overhead hoists etc.,)

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Section 4 – Please give details of any prescribed medication being used for the problems you have mentioned.

Name of medication	How often taken

Section 5 - In relation to the specific medical problems or disability you have referred to, please describe any hospital treatment that has been received.

Name of Hospital	In Patient	Out Patient	Type of Treatment	Last Time Attended / Admitted

Section 6 – Have you filled in :

a) A Housing Application Form Yes ☐ No ☐

b) An Application for housing from a person claiming to be homeless Yes ☐ No ☐

Please give your reference number if you have one ……

Section 7 – Do you have problems with mobility? Yes ☐ No ☐

Do you have difficulty walking? Yes ☐ No ☐

If **YES** are you able to walk unaided Yes ☐ No ☐

Do you use a STICK(S) ☐ CRUTCHES ☐ or ZIMMER FRAME ☐

Can you walk : ½ mile plus ¼ mile 100 yds 10 yds

☐ ☐ ☐ ☐

Are you able to stand without help? Yes ☐ No ☐

Section 8 – Do you have difficulty climbing a flight of stairs?

Yes ☐ No ☐

Do you have difficulty in climbing one or two steps? Yes ☐ No ☐

Do you use a wheelchair? Yes ☐ No ☐

If **YES** do you use the wheelchair outdoors only Yes ☐ No ☐

Do you use an electric scooter ? Yes ☐ No ☐

Indoors sometimes? Yes ☐ No ☐

Indoors always? Yes ☐ No ☐

Do you have problems using lifts? Yes ☐ No ☐

If **YES** give reasons and include any treatment you have had ……

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Name and address of Social Services Officer who we may need to contact for a report

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NB: To enable the medical advisor to recommend the type of property and / or floor level, full details are necessary. Please continue on a separate sheet if necessary.

Do you have difficulty with your hearing? Yes ☐ No ☐

Do you have problems with your sight? Yes ☐ No ☐

Do you have problems with your speech? Yes ☐ No ☐

Do you suffer with incontinence? Yes ☐ No ☐

Do you have difficulty breathing? Yes ☐ No ☐

Section 9

Are you employed ☐ **Unemployed** ☐ **Retired** ☐

Other, please specify ……

What is your current occupation ……

Can you cope with full-time work? Yes ☐ No ☐

Have you had to change occupation Because of your medical condition/disability Yes ☐ No ☐

Are you only capable of part-time work because Of your medical condition/disability? Yes ☐ No ☐

Section 10 - Do you use any of these services regularly?

Home Help Yes ☐ No ☐

Meals on wheels Yes ☐ No ☐

Bath Attendant Yes ☐ No ☐

Ambulance to out-patients Yes ☐ No ☐

Section 11 - Can you do the following things WITHOUT HELP?

Use a bath Yes ☐ No ☐ General Housework Yes ☐ No ☐

Use a toilet Yes ☐ No ☐ Wash (Self) Yes ☐ No ☐

Cook Yes ☐ No ☐ Wash (clothing) Yes ☐ No ☐

Shopping Yes ☐ No ☐ Use public transport Yes ☐ No ☐

Gardening Yes ☐ No ☐

REMARKS (specify where help is given/needed etc.) ……

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Are you able to drive a car unaided ? Yes ☐ No ☐

If no, please specify how your car is adapted ……

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Please tell us how your health problems/disability affect your ability to live in your present housing for example, problems in getting to the toilet, bath or outside. Location of steps and stairs.

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SECTION 12. ASTHMA QUESTIONNAIRE – APPLICANTS / TENANTS

Name and address ……

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How long have you had asthma? ……..

What medication do you take? ……

Regularly ☐ when necessary ☐

Do you smoke? Yes ☐ No ☐

Do you use oxygen (at home)? Yes ☐ No ☐

If yes, how often? ……

When was the last severe attack,
needing the attention of a Doctor? ……

Date of last hospital admission? ……

Number of days in hospital ……..

What does your peak flow measure?
(please complete is able) ……

Have you had any time off work / school because of asthma? Please give details:

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Signature …….. Date ……..

Section 13. Do you have central heating? Yes ☐ No ☐

Please give details of the type of heating in your accommodation.

If you have central heating:-

Is it part of full? …… Gas ☐ or oil fired radiators ☐ Warm air ☐

In which room(s)? …….

If dwelling is not centrally heated, please specify type of heating and in which rooms:-

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Section 14. Do you wish to tell us any other relevant information which will affect the type of accommodation we may offer,

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If it is necessary for us to discuss these problems in more detail, we will contact you

Section 15 . Phobias (A fear or aversion)

Do you suffer from any phobias? ……

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What is the nature of your phobia? ……

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How does it affect you? ……

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When did you first realise you had this problem ……

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What happened during the first incident? ……

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Has the phobia been severe enough for you to seek help from your doctor?

Yes ☐ No ☐

If so, when did you first inform your doctor of the problem? ……

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What treatment was recommended for you? ……...

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What was the outcome of the treatment? ……

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Are you still receiving this treatment? …….....

If you have a phobia of heights / lifts, which of the following applies to you?

a) Completely unable to use a lift / be at height ☐

b) Find using lifts / being at height very difficult and avoid the situation wherever possible ☐

c) Able to use lifts / be at height but feel anxious ☐

How do you manage in buildings with lifts e.g. hospitals, shopping centres?

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Are you able to climb a flight of stairs or do you require accommodation that is all on one level?

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Section 16. Permission to contact your Doctor / Hospital Consultant or any other external and internal Agencies, including Social Services for further information or to make any relevant referral**.**

I am willing for my family doctor, hospital consultant or any other agencies to be consulted if necessary about the conditions stated on this Medical Circumstances Form. (If persons are less than 16 years of age a parent or guardian should sign on behalf of this person).

GP's Name: Full address:

Telephone No:

Name of Hospital: Consultants Name:

Address: Hospital record number (if known)

Social Worker's Name: (If applicable) Office Address:

Telephone Number:

1. THIS DOES NOT NECESSARILY MEAN THAT THESE PERSONS WILL BE CONTACTED.

2. YOU MUST TELL US ABOUT ANY MEDICAL FACTORS AFFECTING YOUR HOUSING APPLICATION OR ANY CHANGE AFFECTING YOUR HOUSING REQUIREMENTS.

Signed …….. Date ……