

Medical self assessment form



We don't request information from your GP or Consultant for an illness or disability so please include as much relevant information as possible. You're also welcome to attach supporting evidence.

If you'd like to provide any information that you'd like to remain confidential between you and our medical adviser, please provide your information in a sealed envelope that includes your name and address and is clearly marked as confidential

Your name	
Address	
GP practice	

The following people included on my application are suffering from an illness and/or disability which is made worse by our current home (include yourself if appropriate):

Name	Date of Birth		
Nature of illness or disability			
Name	Date of Birth		
Details of illness and/or disability			
What treatment are those named above receiving (if any) from a GP or hospital consultant? Include the names and doses of any medicines they are taking. Please provide as much detail as possible. If necessary, please attach further sheets.			
How does your home affect the illness and/or disability of anyone you've included on this form? <small>Please provide details of how it affects them on a daily basis</small>			

What type of home do you currently live in?	House	Flat	Studio	Other
Which floor do you live on <small>(ground, 1st, 2nd etc)</small>	How many stairs are there to your front door?			
Do you have to climb any stairs	Yes	No	If 'yes' how many stairs?	

Do you have the use of a lift	Yes	No
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Please tick the following boxes to show us how you or anyone with an illness and or/ disability that you've included on this form is coping at home	You			Other people in your home		
	able to do	find it difficult	unable to do	able to do	find it difficult	unable to do
Getting in and out of the property						
Getting in and out of the bathroom						
Getting in and out of the toilet						
Getting in and out of the kitchen						
Getting in and out of the bedroom						

What type of home are you looking for to make things easier for you?

What type of support will you need if you are re-housed	Retirement housing	Live in carer	Adaptation for disability
	Dialysis treatment	Separate bedroom	

Other – Please describe:

If an Occupational Therapist from your local council has visited you to try to help resolve the medical problems you're experiencing in your home, please tick the box and provide us with a copy of their most current report.	Yes	No
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Declaration

By completing and signing this form, you're giving us consent to use your personal information purely for the purposes of assessing your application on medical grounds for a transfer with RHP and / or to join our retirement living waiting list on medical grounds. Your information will be strictly limited to RHP and our independent medical adviser. Our medical adviser will be provided with this information to assist us to assess your application. The medical adviser is independent and is not an employee of RHP, but is bound by duties of confidentiality.

You do not need to provide us with this information, but if you do not we may be unable to consider your application on medical grounds and your specific circumstances. You may withdraw your consent at any time, although withdrawing consents means we will not be able to consider any medical grounds in your application to transfer with RHP and/or apply for retirement housing with RHP.

You can view our Privacy Notice which explains the legal basis for the processing of your personal information on our website at www.rhp.org.uk

Please tick this box to confirm that you understand and agree with the above statement.

Print Name: _____ Date: ____|____|_____