The Medical Advisory Service

If you have completed a form within the last 6 months DO NOT complete another one unless there has been a major change in health or you have information which was previously not given.

Please complete all sections as fully as possible. Please write clearly in capital letters and in black or blue ink.

If there is more than one person with medical needs, please ask for additional copies of pages 4 to 7.

Which areas have you applied to? Please tick boxes to select any that apply.

Dundee ☐ Perth and Kinross ☐ Angus ☐ Fife ☐

Which Housing Providers have you applied to? Please tick boxes to select any that apply.

Dundee City Council	☐	Abertay Housing Association	☐
Angus Housing Association	☐	Fairfield Housing Co-operative	☐
Hillcrest Housing Association	☐	Home In Scotland	☐
Sanctuary Scotland Ltd	☐	Caledonia Housing Association	☐
Other	☐	Please give details	

Section 1: About you and your household

About you

Person 1

Full name	
Address	
Contact telephone number	
Date of Birth (dd/mm/yyyy)	
Gender	Male ☐ Female ☐
Do you have medical or special needs?	Yes ☐ No ☐

About the people who will be living with you

Person 2

Full name			
Address			
Contact telephone number			
Date of Birth (dd/mm/yyyy)		Relationship to Person 1	
Gender	Male ☐ Female ☐		
Do they have medical or special needs?	Yes ☐ No ☐		

Person 3

Full name			
Address			
Contact telephone number			
Date of Birth (dd/mm/yyyy)		Relationship to Person 1	
Gender	Male ☐	Female ☐	
Do they have medical or special needs?	Yes ☐	No ☐	

Person 4

Full name			
Address			
Contact telephone number			
Date of Birth (dd/mm/yyyy)		Relationship to Person 1	
Gender	Male ☐	Female ☐	
Do they have medical or special needs?	Yes ☐	No ☐	

Person 5

Full name			
Address			
Contact telephone number			
Date of Birth (dd/mm/yyyy)		Relationship to Person 1	
Gender	Male ☐	Female ☐	
Do they have medical or special needs?	Yes ☐	No ☐	

Person 6

Full name			
Address			
Contact telephone number			
Date of Birth (dd/mm/yyyy)		Relationship to Person 1	
Gender	Male ☐	Female ☐	
Do they have medical or special needs?	Yes ☐	No ☐	

Section 2: Your current housing

Which best describes your present housing situation? Please tick all that apply

An owner-occupier	☐	A Council tenant	☐	A Housing Association tenant	☐
A tenant of a private landlord	☐	Sharing a tenancy	☐	Still in the family home	☐
In "Tied" housing	☐	In student housing	☐	In sheltered housing	☐
Residential home	☐	Nursing home	☐	Hospital and can't return home	☐
Homeless	☐	In homeless accommodation	☐	Temporary with friends/family	☐
If homeless, are you registered with your local Homeless Unit?	☐	If yes, where?			
Other	☐	Please describe			

About the house you are living in now

What type of house do you live in?

Flat/Maisonette	☐
Multi storey flat	☐
Detached/semi detached	☐

Which floor is your house on?

Ground floor	☐
First floor	☐
Second floor or above	☐
Number of steps to entrance of building	☐
Is there a lift to your home?	Y/N

Inside your house

If your home is all on one level, how many?

Bedrooms		Bathrooms		Separate toilet?	Y/N	Living rooms	

If your home has more than one level, how many?

Upstairs	Bedrooms		Bathrooms		Separate toilet?	Y/N	Living rooms	
Downstairs	Bedrooms		Bathrooms		Separate toilet?	Y/N	Living rooms	
How many flights of stairs?								

Are there any adaptations?

Stairlift	Y/N	Level or ramped access	Y/N	Doors widened	Y/N
Level access shower	Y/N	Other fixed adaptations?	Y/N	Please state what	

Section 3: You and your household's medical needs

What sort of housing do you think would meet you and your household's medical need?

Mainstream	☐	Amenity Housing*	☐	Sheltered Housing*	☐
Very Sheltered Housing*	☐	Housing with Care*	☐	Wheelchair Adapted*	☐

* further information will be asked for these, on this form and/or from other health professionals

Do you need to be on a particular floor? (Remember ground floor housing may be limited)

No	☐	Ground floor, all on one level	☐	No more than 1 level up	☐	Not on ground floor	☐

Medical information for each person living in the household with medical or special needs
(If there is more than 1 person in the household with medical or special needs please ask for further copies of pages 4 – 7)

Person 1, Name:

Why do you feel you need to move on medical grounds?

If applying for Sheltered Housing please tell us why you feel you require to have warden cover

What is the name, address and phone number of:

Your own GP	Your Care Manager
Any hospital consultant	Your Home Care Organiser
Your Social Worker	Other support provider

What are your medical problems?

What treatment do you receive?

What help do you have at present? *Please tick all that apply*

Community Alarm	☐	Very Sheltered Housing Warden	☐
Sheltered Housing Warden	☐	Housing with Care	☐

		How often do you receive this help? (e.g. daily,weekly)
Relative/ Neighbour	☐	
Social Care Officer	☐	
Home Help	☐	
Meals on Wheels	☐	
District Nurse	☐	
Community Health Nurse	☐	
Physiotherapist	☐	
Occupational Therapist	☐	
Day Care/Hospital	☐	

What day-to-day difficulties do you have?

Do you have any difficulties with walking? Y/N

How far can you comfortably walk on an average day?

No major problems	☐	100 – 400 metres (about ¼ mile)	☐	50 - 100 metres	☐
20 – 50 metres	☐	Less than 10 metres	☐		

Do you use any walking aids?

Wheelchair indoors	☐	Wheelchair outdoors	☐	Zimmer frame	☐
Crutches	☐	Walking stick	☐		

Do you find stairs difficult because of health problems? Y/N

On an average day how many steps can you manage to climb?

More than 30	☐	20-30	☐	15-20	☐
10-15	☐	5-10	☐	1-5	☐
None	☐				

Do you go out

Alone?	Yes ☐ No ☐	Accompanied?	Yes ☐ No ☐

Do you have other problems with day-to-day activities? Yes ☐ No ☐

Please tell us about these on the form below. Use the codes to indicate level of ability.

Codes

1 No help required
2 Don't receive help but struggle
3 Able to do alone but with the help of equipment (please state what equipment used)
4 Able to do but need some help from someone else (please state who that is)
5 Unable to do or need maximum help

Activity	Code	Comments	Activity	Code	Comments
On/off chair			Dressing		
On/off bed			Housework		
Toileting			Laundry		
Continence Bladder/Bowel			Preparing food/cooking		
Bathing/Showering			Shopping		
Washing hands/face			Budgeting		

Section 4: Supporting comments

PLEASE NOTE: If a report is needed from your GP, consultant or another health professional, the Medical Adviser will contact them directly provided that you have given your consent in section 5 of this form. DO NOT take this form to your GP.

This section should be completed and signed on behalf of the person with special and/or medical needs by anyone in a position to support this application. This could be an occupational therapist, a social worker, a district nurse, a home help or a member of your immediate family who is aware of your current needs, but not by yourself.

Name	
Address	
Contact telephone number	
Designation	

Please give us any information you think might be relevant to the application.

Signed (NB. Not the applicant) _____

Section 5: Consent

Consent to contact your GP or other doctor involved in your care

This should be signed by the person for whom the medical and/or special needs assessment is requested or by someone who has legal authority to act on their behalf.

I agree to my own doctor, GP or Consultant, divulging to the Council's Medical Adviser, details appropriate to this application. I am aware that under the Access to Medical Records Act, I have the right of access to this information from my GP. I understand that the information given may be used anonymously for health and/or housing research.

Signed _____ Date _____

NB. If you have signed this form on behalf of the person with medical and/or special needs please indicate what authority you have to act on their behalf:

Name	
Status	Legal Power of Attorney/ Financial Guardian/ Welfare Guardian (please delete those that do not apply)

Consent for application to be considered by a Special Needs Panel

This should be signed by the person for whom the medical and/or special needs assessment is requested or by someone who has legal authority to act on their behalf.

I consent for my application to be considered for any of the Special Needs Panels if it is deemed to be the most appropriate to my situation.

The current Special Needs Panels are the Physical Disability Panel, the Very Sheltered Housing/Housing with Care Panel, and the Special Needs Panel for persons with enduring mental illness or learning disability.

The Special Needs Panel will consider details of my situation, including any relevant medical detail, which will be discussed between the attending professionals. These professionals may include representatives from Occupational Therapy, Community Psychiatric Nursing Service, Social Work Department, Housing Providers and the Medical Adviser of NHS Tayside.

The allocation of a medical priority may depend on other professionals being asked to submit an Assessment of Need and this may require a visit from one of the groups noted above so the application can be discussed in more detail. If I do not consent to this the Housing Provider and the Medical Adviser of Tayside Primary Care NHS Trust will be the only parties to consider my application and to award any priority based on the available information.

Signed _____ Date _____

NB. If you have signed this form on behalf of the person with medical and/or special needs please indicate what authority you have to act on their behalf:

Name	
Status	Legal Power of Attorney/ Financial Guardian/ Welfare Guardian (please delete those that do not apply)

Section 6: Additional information for Very Sheltered Housing and Housing with Care

Only complete this section if you are applying for very sheltered housing or housing with care.

These are specialised types of housing for older people and more information about them can be found on page 24 of the Dundee Housing Application Form.

If you are applying for Very Sheltered Housing or Housing with Care, please complete this section in addition to the rest of this form. You will also need to make a housing application to all the providers you wish to be considered for.

If you have any other evidence to support these extra needs please submit it, or provide contact details for those who can supply it:

Name	Address	Contact number	Designation

Are your medical needs well controlled?

Yes	No	Comments

Do your care needs vary greatly from day to day?

Yes	No	If Yes, please give further details

Do you have frequent falls?

Yes	No	If Yes, please give further details e.g. circumstances, frequency

Have you any memory problems?

Yes	No	If Yes, please give further details

Have you any mental health issues?

Yes	No	If Yes, please give further details

Are there any issues regarding personal safety?

Yes	No	If Yes, please give further details

Are you able to provide snack meals for yourself?

Yes	No	Comments

Is there any other information you think might be relevant to your application?

Signed (person applying for Very Sheltered Housing or Housing with Care)	
Date	

Signature of person acting on behalf of applicant	
Date	
Status	Legal Power of Attorney/ Financial Guardian/ Welfare Guardian. (please delete those that do not apply)