



## Medical Assessment

Please print in BLOCK LETTERS with a black or blue pen

This form is to be completed by the client's health care professional to provide information about the client's medical condition. Please mark relevant boxes with a  If you need more room to answer any questions, please include details on a separate page and attach it to this form. For information or assistance with this form, phone **1300 Housing 24** hours a day, seven days a week.

Client reference number

T-File number

Application reference number

Payment reference number

Name of social housing provider

### Client details

Title  
Mr, Mrs, Ms, Miss

Last name or family name

Given name (s)

Unit/House number

Street/Avenue

Town /Suburb

Postcode

### Notice and Authorisation

Under the *Housing Act 2001*, the *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002*, you must be told why your personal information (including health information) is being collected, how it will be used and whether it will be given or exchanged with another party.

**Notice:** your personal information and any relevant information provided on this form will be exchanged between social housing providers (public, community and Aboriginal housing) for the purpose of processing your application.

### Authorisation

- I have read and understand the above notice.
- I give permission for medical details affecting my need for housing to be released to the above named social housing provider and, if necessary, for my doctor/health care professional to discuss these details on my behalf with the social housing provider.

Signature

Date



**4. Please provide details of the client's medical condition and the affects it has on both their housing needs and their ability to access and sustain housing**

<b>Name of medical condition(s)</b>	
<b>Description of condition(s)</b>	
<b>How the condition(s) affect the client's housing needs?</b>	

**Frequency of visits to the practitioner**


**Overall impact of the condition(s) on the client's wellbeing (please tick)**

- Minor
- Moderate
- Severe

**5. What is likely duration of the condition(s) (please tick)?**

- Short (0 - 2 years)
- Medium (2 - 5 years)
- Long (5 years or more)

**6. Do any of the above medical conditions restrict the client from accessing the required health service by walking or taking public transport?**

- Yes                       No → Go to next question

Please provide details


**7. Is the client's current accommodation exacerbating their medical condition(s) (e.g. lack of room for specialised medical equipment)?**

Yes

No

→ Go to next question

↓ Please provide details


**8. Is the client's mobility restricted?**

Yes

No

→ Go to next question

↓ Please provide details below


**9. Can the client manage steps/stairs?**

Yes

No

↓ If yes, how many?

1-2

6-12

3-5

12 or more

**10. Does the client need accommodation that is modified (e.g. hobless shower, 1/4 turn taps, wheelchair access)?**

Yes

No

↓ Please provide details below


**11. Does the client's condition(s) affect their ability to look for suitable private rental accommodation?**

Yes

No

→ Go to next question

Please provide details


**12. Does the client have extra expenses because of their medical condition(s)?**

Yes

No

→ Go to next question

List the expenses incurred on a regular basis which may cause financial hardship to the client


**13. Does the client need to live in a particular area to access support services?**

Yes

No

→ Go to next question

What location is required?

Name of location

**14. Does the client have difficulty with independent living skills (e.g. unable to cook, clean and shop for themselves)?**

Yes → Go to next question

No → Go to question 18

**15. Has an independent living skills assessment been done?**

Yes

No

→ Go to next question

Please attach the independent living skills assessment

**16. Does the client currently have a carer?**

Yes → Go to next question

No → Go to question 18

17. Is the carer (please tick):

Part time

Full time

On a needs basis

17a. Does the carer live with the client?

Yes

No

18. Does the client need regular support?

Yes

No → Go to next question

List support


19. Do psychological issues affect the client's ability to cope?

Yes → Go to next question

No → Go to question 23

20. Does the condition(s) require medication for the client to live independently?

Yes  
↓  
Give details below

No → Go to next question


21. Is the client's condition(s) supported by other health professionals?

Yes  
↓  
Please tick all that apply

No → Go to next question

Mental health workers

Counsellors

Psychiatrists

Other health professionals (give details below)

↓

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22. Does the client have a particular dwelling requirement as a result of the condition(s)?

Yes

No

→ Go to next question

Describe requirements below


23. Would you like to add further comments to support the client's needs?

Yes

No

Please give details


### Checklist

If appropriate, have you attached copies of relevant documentation such as:

Independent living skills assessment

Occupational Therapist's report detailing required modifications

Other documentation (give details below)


Practitioner's name

Signature

Date

**Thank you for taking time to complete this form**