RUTHERGLEN & CAMBUSLANG HOUSING ASSOCIATION
16 FARMELOAN ROAD RUTHERGLEN
0141 647 4917

MEDICAL ASSESSMENT FORM

NAME	
ADDRESS	
DATE OF BIRTH	
TEL. NO.	

PLEASE TELL US WHAT HEALTH PROBLEM YOU OR ANYONE ELSE IN YOUR HOUSEHOLD HAVE

_____

_____

_____

_____

_____

CURRENT ACCOMMODATION - TYPE OF HOME (PLEASE TICK IN THE APPROPRIATE BOX):

FLAT : ☐	**HOUSE :** ☐

IF IT IS A FLAT, WHAT LEVEL IS IT ON _____

WHAT TYPE OF PROPERTY DO YOU WISH TO MOVE TO:

_____

_____

_____

GETTING AROUND YOUR HOME

(PLEASE TICK IN THE APPROPRIATE BOX FOR THE REMAINDER OF THE FORM)

1. **DO YOU HAVE DIFFICULTY WALKING : YES** ☐ **NO** ☐ **SOME DIFFICULTY** ☐

2. **IF YES, DO YOU USE ANY OF THESE TO HELP GET ARROUND ?**

   WALKING STICK ☐ **WALKING FRAME** ☐ **WHEELCHAIR** ☐

3. **IF YOU USE A WHEELCHAIR, DO YOU USE IT INDOORS OR OUTDOORS ?**

   BOTH ☐ **OUTDOORS ONLY** ☐

4. DO YOU HAVE ANY DIFFICULTY CLIMBING STAIRS? YES ☐ NO☐

IF YES, PLEASE GIVE DETAILS

_____

_____

5. PLEASE INDICATE HOW MANY STAIRS THERE ARE AT YOUR HOME

INSIDE : _____ **OUTSIDE :** _____

6. ARE THERE HANDRAILS ON THE STAIRS ? YES ☐ NO ☐

7. ARE THEY ON ONE SIDE OR BOTH SIDES ? ONE SIDE ☐ BOTH SIDES ☐

8. HOW MANY STAIRS WOULD YOU BE ABLE TO MANAGE EASILY ? _____

9. DO YOU HAVE TO GO UPSTAIRS TO THE : TOILET : ☐ BATHROOM : ☐ BEDROOM : ☐

10. DO YOU REQUIRE, ANY EQUIPMENT TO HELP YOU WITH THE STAIRS ?

YES : ☐ **NO :** ☐

(PLEASE DESCRIBE) : _____

_____

BATHROOM

1. WHAT DOES YOUR BATHROOM HAVE ?

A BATH ☐ **A SHOWER OVER THE BATH** ☐
A SEPARATE SHOWER UNIT ☐ **A WET FLOOR AREA** ☐

2. DO YOU HAVE ANY DIFFICULTY USING THE BATH, SHOWER OR TOILET ?

YES : ☐ **NO :** ☐

IF YES, PLEASE TELL US ABOUT IT : _____

_____

3. DO YOU HAVE ANY AIDS OR EQUIPMENT TO ASSSIST YOU IN THE BATHROOM

YES ☐ **NO** ☐

IF YES, PLEASE TELL US ABOUT IT : _____

_____

DISABILITY BENEFITS

1. DO YOU RECEIVE ANY BENEFITS DUE TO YOUR HEALTH PROBLEMS OR DISABILITY ?

YES ☐ NO ☐

IF YES, PLEASE TELL US WHCH BENEFIT AND THE RATE E.G. MOBILITY,MIDDLE RATE

_____

OTHER HEALTH PROBLEMS

1. IF YOUR HEALTH PROBLEM IS NOT COVERED BY ANY OF THE ABOVE QUESTIONS , PLEASE TELL US HOW YOUR HOUSING AFFECTS YOU ILLNESS OR DISABILITY, AND HOW YOU FEEL A MOVE WOULD HELP.

_____

_____

_____

_____

HOSPITAL

1. DO YOU REGULARLY ATTEND A HOSPITAL OR CLINIC ? YES ☐ NO ☐
2. IF SO, WHICH HOSPITAL / CLINIC ? _____
3. WHAT IS YOUR CONSULTANT'S NAME ? _____

FAMILY DOCTOR

1. WHAT IS YOUR DOCTOR'S NAME ? _____
2. ADDRESS : _____

_____

1. IF YOU GET REGULAR SUPPORT FROM ANYONE ELSE, SUCH AS DISTRICT NURSE OR OCCUPATIONAL THERAPIST, PLEASE GIVE THEIR NAME AND ADDRESS.

_____

DO WE HAVE YOUR PERMISSION TO CONTACT ANY OF THE ABOVE PEOPLE IF WE NEED MORE INFORMATION ABOUT YOUR HEALTH ?

YES ☐ NO ☐

PLEASE SIGN YOUR NAME HERE : _____

DATE_____