



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

To the health care professional

The client has presented to the social housing provider requesting housing assistance. Social housing providers are committed to allocating suitable housing and creating sustainable tenancies. When completing this form it is important to take into account that information you provide will be most helpful to the client if it reflects your professional opinion. The information you provide will assist in accurately assessing the client's housing need, including particular housing features, such as type or location.

To assist in this process the following information is required.

Details of health care professional completing this form

Title	Mr, Mrs, Ms, Miss, Dr		<input type="text"/>
Last name or family name	<input type="text"/>		
Of (practitioner's address) Organisation Name	<input type="text"/>		
Street number	<input type="text"/>		
Street/Avenue	<input type="text"/>		
Town /Suburb	<input type="text"/>	Postcode	<input type="text"/>
Phone	<input type="text"/>	Email	<input type="text"/>
Provider number	<input type="text"/>		

1. Are you a (please tick applicable)?

- General practitioner
- Specialist
- Allied health worker

2. Please describe your field of expertise

3. How long has the client been one of your patients?

- One consultation only
- Weeks
- Months
- Years

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

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

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

Please provide details

 No

→ Go to next question

8. Is the client's mobility restricted?

 Yes

Please provide details below

 No

→ Go to next question

9. Can the client manage steps/stairs?

 Yes

If yes, how many?

 No 1-2 3-5 6-12 12 or more

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

 Yes

Please provide details below

 No

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

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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

No → Go to next question

↓
Give details below

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

Yes

No → Go to next question

↓
Please tick all that apply

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