YORKHILL HOUSING ASSOCIATION LIMITED

<u>CONFIDENTIAL</u>

HOUSING APPLICATION – MEDICAL ASSESSMENT FORM

Name: ……………………………………………… Date of Birth: ………………………

Address: ……………………………………………...

……………………………………………… Postcode: ………………………..

………………………………………………

Telephone: ………………………………………………

- Please tell us what health problems you have.

  ………………………………………………………………………………………………..

  ………………………………………………………………………………………………..

  ………………………………………………………………………………………………..

- The length of time you have been affected by it.

  ………………………………………………………………………………………………..

- What medication are you currently taking?

  ………………………………………………………………………………………………..

  ………………………………………………………………………………………………..

  ………………………………………………………………………………………………

- How has this illness affected your life?

  ………………………………………………………………………………………………..

  ………………………………………………………………………………………………..

  ………………………………………………………………………………………………..

- How do you think your illness will be improved by re-housing?

  ……………………………………………………………………………………………………..

  ……………………………………………………………………………………………………..

  ……………………………………………………………………………………………………..

- Are you receiving support? Please provide details.

  ……………………………………………………………………………………………………..

  ……………………………………………………………………………………………………..

  ……………………………………………………………………………………………………..

- Is this support ongoing?

  ……………………………………………………………………………………………………..

- Any other relevant information.

  ……………………………………………………………………………………………………..

  ……………………………………………………………………………………………………..

  …………………………………………………………………………………………………….

- Do we have your permission to contact your GP if we need more information about your health? **Yes** **No**

  Doctors name and address:

  ……

  ………………………………………………………………………………………………………..

Signed: ……………………………………………… Date: ………………………………….