Please complete and return this form to:

Customer Service Support
Cray House 3 Maidstone Road Sidcup DA14 5HU
Tel: 0300 456 9996
E-mail: customerservicesupport@lqgroup.org.uk

Medical Assessment Form

Transfer Reference Number	Please quote this number when writing to us

This form is to be completed so that our independent medical advisor can make an accurate assessment of your medical difficulties in relation to your current housing circumstances.

The information will be used to assess whether:

- You qualify as a medical priority.
- You need accessible accommodation (i.e. a ground floor flat).
- You need an additional room in your home.

The information is confidential and will only be used for this purpose.

Please complete sections A - D as fully as possible before signing section E

Section A: Personal Details

Name(s)		
Address		
		Postcode
Tel (home)	Tel (eve)	Tel (mobile)

Please provide details of the person(s) for whom a medical assessment is requested

Name	Gender	Date of Birth	Relationship to Tenant

Section B: Medical Self-Assessment

Does anyone consider themselves disabled? DYES DNO

If YES, please give details below

Name	Nature of disability

Does anyone have a diagnosed medical condition? DYES DNO

If YES, please give details below

Name	Medical condition

Is anyone taking prescribed medication for their disability/condition? DYES DNO

If YES, please give details below (please include a copy of the prescription if possible)

Name	Medication	Dosage	How often?	Date started

Is anyone receiving any other treatment for their disability/condition? DYES DNO

If YES, please give details below

Name	Treatment

Does anyone use a wheelchair? DYES DNO

If YES, please give details below

Name	Location		
	D Inside the home	D Outside the home	D Both
	D Inside the home	D Outside the home	D Both
	D Inside the home	D Outside the home	D Both
	D Inside the home	D Outside the home	D Both

Has anyone been admitted to hospital as a result of their disability/condition? D YES D NO

If YES, please give details below

Name	How many times?	Last admission date

Is anyone awaiting surgery in relation to their disability/condition? D YES D NO

If YES, please state date of surgery

Section C: Your Current Home

Has your home been adapted in any way to assist with day-to-day living? D YES D NO

If YES, please give details below

Please describe how you feel any disability/condition listed is affected by your current home

What type of accommodation do you feel is needed?

Please explain how you feel the medical problems would be relieved by a move

Section D: Medical Contacts

If anyone is receiving medication/treatment, please state the doctor's name and contact details

Name	Doctor's name and contact details
	Name
	Address
	Telephone

If anyone is attending hospital, please state the hospital's name and contact details

Name	Hospital's details
	Name of department/specialist
	Address
	Telephone

If anyone is receiving assistance from another service, please state the name and contact details

Name	Service provider's details
	Name of person/organisation providing support
	Address
	Telephone

Section E: Declaration

I/We* declare that the information given on this form is true and correct.
I/We* will notify London and Quadrant Housing Trust of any changes to the information given.
I/We* give consent for London and Quadrant Housing Trust's medical advisor to obtain further medical information from my/our* doctor(s) or other health professional(s) as required.

Each person with a disability or medical condition listed in this form should sign below. A parent or guardian should sign for any person(s) under 16 years of age.

Signed	Signed	Signed
Name	Name	Name
Date	Date	Date