# *Tayside Medical Advisory Service (TMAS3)*

Which Housing Provider, in which area, have you applied to/will be applying to?
Please tick box to select (any that apply) NOTE, MEDICAL PRIORITY CAN ONLY APPLY IN ONE AREA

| | *DCC* | *P&K* | *ACC* | *FCC* | | *DCC* | *P&K* | *ACC* | *FCC* |
|---|---|---|---|---|---|---|---|---|---|
| **DUNDEE CITY COUNCIL** | ☐ | ☐ | ☐ | ☐ | **FAIRFIELD HOUSING CO-OPERATIVE** | ☐ | ☐ | ☐ | ☐ |
| **PERTH & KINROSS CITY COUNCIL** | ☐ | ☐ | ☐ | ☐ | **HILLCREST HOUSING ASSOCIATION** | ☐ | ☐ | ☐ | ☐ |
| **ANGUS CITY COUNCIL** | ☐ | ☐ | ☐ | ☐ | **HOME IN SCOTLAND** | ☐ | ☐ | ☐ | ☐ |
| **FIFE CITY COUNCIL** | ☐ | ☐ | ☐ | ☐ | **SANCTUARY SCOTLAND LTD** | ☐ | ☐ | ☐ | ☐ |
| **ABERTAY HOUSING ASSOCIATION** | ☐ | ☐ | ☐ | ☐ | **SERVITE HOUSING ASSOCIATION** | ☐ | ☐ | ☐ | ☐ |
| **ANGUS HOUSING ASSOCIATION** | ☐ | ☐ | ☐ | ☐ | **OTHER (please state)** | ☐ | ☐ | ☐ | ☐ |

## *Special Needs and Medical Assessment Form*

Reference No:

## *SECTION A: ABOUT YOU AND YOUR HOUSEHOLD*

1. Please tell us about the applicant (this means the head of the household):

| Name | | Gender (M/F) | Date of Birth |
|---|---|---|---|
| | APPLICANT | | |

2. Please tell us about the person or persons with medical and/or special needs if different from above:

| Name | Relationship to Applicant (e.g. son; aunt) | Gender (M/F) | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |

3. Please tell us about all the other people who live in your household. **Please mark with a cross ('X') in the last column who will be housed or re-housed, with the person with special and/or medical needs**:

| Name | Relationship to Applicant (e.g. daughter, uncle) | Gender (M/F) | Date of Birth | 'X' |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| 4. Current Address:<br>Postcode: | 5. Tel. No: |
|---|---|

## SECTION B: ABOUT YOUR CURRENT HOUSING SITUATION

1. Are you currently:

| | (✓) |
|---|---|
| • An owner-occupier | |
| • A Council tenant | |
| • A Housing Association tenant | |
| • A Private tenant | |
| • Living with parents | |
| • Living with relatives | |
| • In "Tied" Accommodation | |

| | (✓) |
|---|---|
| • Lodging with friends | |
| • Sharing a tenancy | |
| • Living in a bed and breakfast/hotel | |
| • Living in student accommodation | |
| • Homeless | |
| • Other (Please tell us below) | |
| | |

2. What type of housing do you presently live in?:

| | (✓) |
|---|---|
| House | |
| Flat | |
| Maisonette | |
| Other | |

3. Please tell us about the number of rooms in your home:

| | UPSTAIRS | DOWNSTAIRS |
|---|---|---|
| Number of bedrooms | | |
| Number of bathrooms | | |
| Number of toilets | | |
| Number of public rooms | | |

4. On what level is your current home (e.g. ground floor, 1st floor etc):

5. If you live on the GROUND FLOOR , please tell us –

| | (✓) Yes | No | **If YES**: how many steps? |
|---|---|---|---|
| (a.) are there any steps at your front door or up to your house? | | | |
| (b.) are there any inside steps in your house? | | | |

6. Please tell us about any existing or proposed adaptations that have been made, or which are going to be made, to your current home (✓):

| | In Place | Applied for | Accepted | Refused |
|---|---|---|---|---|
| Ramped/Level Access | | | | |
| Doors Widened | | | | |
| Level Access Shower | | | | |
| Stair Lift | | | | |
| Other Fixed Adaptation (describe) | | | | |

7. Is there a lift in your current building? YES ☐ NO ☐

8. Is the area around your home level? YES ☐ NO ☐

If NO: please give details:

9. What type of housing do you think will meet your housing need?(✓):

| | |
|---|---|
| • Adapted Housing | |
| • Amenity Housing | |
| • Ground Floor Housing on one level | |
| • Mainstream Housing | |
| • Mainstream Housing with Support | |

| | |
|---|---|
| • Sheltered Housing | |
| • Very Sheltered Housing | |
| • Housing with Care | |
| • Wheelchair Adapted Housing | |
| | |

• Other – please specify in this box:

## *SECTION C: ABOUT THE AREA WHERE YOU LIVE*

1. Please tell us about how far your current home is from the following services (✓):

| | Under ½ mile | Between ½ and 1 mile | Over 1 mile |
|---|---|---|---|
| • GP/family doctor | | | |
| • family members who provide you with care | | | |
| • your local shops | | | |
| • a local bus stop | | | |
| • your school | | | |

2. If noise, stress or tension affects anyone in your household, please tell us:-

| | PERSON 1 | PERSON 2 |
|---|---|---|
| (a.) who is affected in the household? | | |
| (b.) what causes noise, stress or tension? | | |
| (c.) what action has been taken? | | |

## *SECTION D: ABOUT THE HELP YOU RECEIVE*

1. What is the name and address of the doctor of the person with medical and/or special needs?:

2. What is the name and address of the social worker, care manager, home care organiser or other support provider for the person with medical and/or special needs?:

3. Please tell us about the support services received by the person with medical and/or special needs (if any):

| | How often do you/they receive this help? |
|---|---|
| Warden<br>Sheltered Housing ☐<br>Very Sheltered Housing ☐<br>Housing with Care ☐ | |
| Home Help | |
| Occupational Therapist | |
| Day Care/Hospital | |
| Meals on Wheels | |
| District Nurse | |
| Community Mental Health Nurse | |
| Other – please specify: | |

4. Does the person with medical and/or special needs use any of the following aids?:

| | (✓) |
|---|---|
| Zimmer Frame | |
| Wheelchair – indoors | |
| Wheelchair – outdoors | |
| Walking Stick | |
| Other Aid (please tell us what aid is used) | |

5. Does the person with medical and/or special needs have or receive:

| | (✓) |
|---|---|
| An orange badge | |
| A travel concession award or taxi card | |
| Disability Living Allowance – care component | |
| Disability Living Allowance – mobility component | |
| Severe Disablement Allowance | |
| Attendance Allowance – higher rate | |
| Attendance Allowance – lower rate | |
| Payments from the Independent Living Fund | |

## *SECTION E: ABOUT THE HELP YOU NEED*

1. Please tell us about the help the person with medical and/or special needs requires with the activities listed below:

| | No Help (✓) | What help is provided? | How often is this help provided? | If you think more or less help is required, please specify below: |
|---|---|---|---|---|
| Getting out of bed | | | | |
| Dressing | | | | |
| Washing your hands/face | | | | |
| Going to the toilet | | | | |
| Bathing | | | | |
| Preparing food | | | | |
| Cooking | | | | |
| Rising from a chair | | | | |
| Moving about indoors | | | | |
| Moving about outdoors | | | | |
| Budgeting | | | | |
| Shopping | | | | |
| Laundry | | | | |

## *SECTION F: STATEMENT IN SUPPORT OF APPLICATION*

*This section can be completed on behalf of the person with special and/or medical needs by anyone in a position to support this application.*

*This could be an occupational therapist, a social worker, a district nurse, a home help or a member of your immediate family who is aware of your current needs.*

***If a report is needed from your GP, consultant or another health professional, the Medical Adviser will contact them directly provided that you have given your consent in section H of this form. Do NOT take this form to your GP.***

| Name: | |
|---|---|
| Address: | |
| Designation: | Telephone: |

*Please provide supporting comments below (we would be grateful for an opinion as to why the current housing is unsuitable for the person with the medical condition and/or with special needs within your statement):*

| Signature: | Date: |
|---|---|

## SECTION G: CONSENT FOR CONSIDERATION BY SPECIAL NEEDS PANEL

*NB. It is important that the person signing this consent is the person for whom the special needs and/or medical assessment is requested or someone who has legal authority to act on their behalf.*

I am happy for my application to be considered for any of the Special Needs Panels if this is considered to be in my best interests. The Special Needs Panel may be required to consider details of my situation, including any relevant medical detail, which may be discussed between the attending professionals. These professionals may include representatives from Occupational Therapy, Community Psychiatric Nursing Service, Social Work Department, Housing Providers and the Medical Adviser of Tayside Primary Care Trust.

It may be that the allocation of a priority may depend on other professionals being asked to visit and/or submit an assessment of need. If I do not consent to this, the Housing Provider and the Medical Adviser of Tayside Primary Care NHS Trust will be the only parties to consider my application and to award any priority based on the available information.

I understand that a representative of the social work department may contact and/or visit me for care assessment purposes. A health professional may also contact and/or visit me and that a housing officer from the participating housing organisations may arrange to visit me to discuss this application in more detail.

The current Special Needs Panels are the Physical Disability Panel, the Very Sheltered Housing/Housing with Care Panel, and the Special Needs Panel for persons with enduring mental illness or learning disability, and I consent to my application being considered by any of these Panels if it is deemed to be the most appropriate to my situation.

Signed: ______________________________ Date: ______________________________

Address: ____________________________________________________________________

## SECTION H: CONSENT TO CONTACT MY DOCTOR

*It is important that the person signing this consent is the person for whom the medical and/or special needs assessment is requested or someone who has legal authority to act on their behalf.*

I agree to my own doctor divulging to the Council's Medical Adviser, details appropriate to this application and I am aware that under the Access to Medical Records Act, I have the right of access to this information from my GP. I understand that the information given *may* be used anonymously for health and/or housing research.

Signed: ______________________________ Date: ______________________________

**NB. If you have signed this form on behalf of the person with medical and/or special needs, please indicate what authority you have to act on their behalf:**

## SECTION I: ABOUT ILL-HEALTH, PHYSICAL AND MEDICAL PROBLEMS

1. Please tell us about any physical and/or mental health problems from which the person with medical and/or special needs currently suffers.

   *The Community Medical Adviser may contact the appropriate GP to verify this information.*

   Diagnosis (Name of Illness):

   Medication:

2. Please tell us why the current housing is unsuitable for the person with medical and/or special needs:

3. Please tell us why you want to move from your current address:

| | Yes | No |
|---|---|---|
| 4. Does the person with special and/or medical needs have considerable difficulty, or experience, pain when walking? | | |

- if YES, please tell us about the distance that can be comfortably walked (✓):

| Less than 20 metres | 20 to 50 metres | 50 to 100 metres | Over 100 metres |
|---|---|---|---|
| | | | |

| | Yes | No |
|---|---|---|
| 5. Does the person with special and/or medical needs have considerable difficulty, or experience, pain when climbing stairs? | | |

- if YES, please tell us the number of flights of steps that can be comfortably climbed (✓):

| 2 flights of steps | 1 flight of steps | Less than 1 flight of steps | If less than 1 flight, how many steps |
|---|---|---|---|
| | | | |