

**Private and Confidential**

Runnymede Civic Centre, Station Road  
Addlestone, Surrey KT15 2AH

**REFERENCE NUMBER:**

Tel: 01932 838383  
Fax: 01932 838384  
DX 46350 ADDLESTON

[www.runnymede.gov.uk](http://www.runnymede.gov.uk)

## **APPLICATION FOR REHOUSING – MEDICAL ASSESSMENT**

|                |  |
|----------------|--|
| <b>Name</b>    |  |
| <b>Address</b> |  |
|                |  |
|                |  |

**When to use this form**

If an applicant, or a member of his/her family, has an illness or disability which could be helped or eased by moving to alternative accommodation, then an application for medical priority can be made.

Where the medical factors concern you or your children under the age of 16, complete and sign the declaration in section (B). If the medical factors concern another member of your household, each one concerned must complete and sign one of the declarations in section (C).

**Assessment of your medical circumstances**

Once we have received a completed medical form, we will seek the advice of our Medical Advisor. Your case will be considered and possible outcomes will be:

- 1) No medical priority will be awarded if it is felt that any illness or disability could not be helped or eased by moving to alternative accommodation or is not sufficiently serious to warrant additional priority.
- 2) Medical priority can be awarded to your housing application and this will be either:
  - Low priority
  - Or
  - High priority
- 3) In exceptional cases we may decide that your medical circumstances are so serious or urgent that we award emergency medical overriding priority.
- 4) In some cases our Medical Advisor may require further information before a recommendation can be made. You may be asked for more information or we may need to contact your GP/ Specialist.

**Do I need to get a Doctor’s letter?**

You can include accompanying/supporting letters if you have any. Your application will be considered by the Council’s Medical Advisor who will make contact with your own GP/Specialist if necessary. It is important for the Medical Advisor to have as much information as possible. Please make sure you answer every question on this form.

**When we may seek further medical information**

Whenever possible, the assessment will be made on the information you have provided. Further information from GP/ Specialist may be necessary in some cases but this will only be sought where the patient (or guardian) has given express permission. This is done by completing the “Authority to Disclose” section at the end of this form

**LIST ALL MEMBERS OF THE APPLICANT'S/TENANT'S HOUSEHOLD**

| SURNAME | FIRST NAME(S) | MALE/FEMALE | RELATIONSHIP | DATE OF BIRTH |
|---------|---------------|-------------|--------------|---------------|
|         |               |             |              |               |
|         |               |             |              |               |
|         |               |             |              |               |
|         |               |             |              |               |
|         |               |             |              |               |
|         |               |             |              |               |

**(A) SECTION TO BE COMPLETED BY APPLICANT IN RESPECT OF HIS/HER OWN ILLNESS OR THAT OF A MEMBER OF HIS/HER HOUSEHOLD**

The following members of my household are suffering from the illness or disability stated:

NAME ..... ILLNESS/DISABILITY.....

NAME: ..... ILLNESS/DISABILITY.....

NAME: ..... ILLNESS/DISABILITY.....

ADDRESS:  
 .....  
 .....

POSTCODE: ..... TELEPHONE NO:.....

List all relevant medical conditions:

1. ....
2. ....
3. ....
4. ....
5. ....
6. ....

Please list the names of all tablets/medicines prescribed by your Doctor and how often you/they are taking them. Please give a copy of your/their repeat prescription form if available. If this is not available refer to bottle or box for name of medication.

| Name of tablet/medicine<br>E.g Ibuprofen | How Many/How Many?<br>E.g 400mg – 3 times a day | Since When<br>E.g 1998 |
|--|---|------------------------|
| 1.                                       |   |                        |
| 2.                                       |   |                        |
| 3.                                       |   |                        |
| 4.                                       |   |                        |
| 5.                                       |   |                        |

**What is the name, address and telephone number of your/their doctor?**

**Name:** .....

**Address:**.....  
.....  
.....

**Telephone No:** .....

**If you/they are receiving treatment from a hospital doctor, please give their name, contact address and telephone number:**

**Name:**.....

**Address:**.....  
.....  
.....

**Telephone No:** .....

**ABOUT YOUR CURRENT ACCOMMODATION**

**Do you live in a:**

Bungalow  Flat (with lift)

House  Flat (without lift)

Maisonette (with lift)  Caravan

Maisonette (without lift)  Homeless  go straight to next section on medical information

Other  Please describe:  
.....  
.....

**Which floor do you live on?**

Basement  Ground  First  Second  Third or higher  (please specify)

**Do you have:**

A steep approach to your property? YES  NO

Steps outside the front door? YES  NO  If YES, how many?

Stairs inside the property? YES  NO  If YES, how many?

**What sort of heating do you have?**

Central Heating (Gas or Electric)  Individual Fires (Gas or Electric)

Warm Air Heating (Gas or Electric)  I do not have any heating

Other (please describe)  
.....  
.....

**Do you have an Inside Toilet?**

YES  NO  Is it on the same floor as the rest of your accommodation? YES  NO

**Do you have the use of a Bath or Shower?**

Bath YES  NO  Shower YES  NO

**MEDICAL INFORMATION**

**How do your/their problems/disability affect you/them in your present home?** Continue on a separate sheet if necessary. Please leave blank if homeless

.....  
.....  
.....  
.....

**How could these difficulties be helped by re-housing?**

.....  
.....  
.....

**Have any special adaptations been made to your home for your/their benefit?** (please give details)

.....  
.....  
.....

**Are you or the person who is disabled or has ill health a registered disabled person?**

YES  NO

**If YES please tick all relevant boxes**

Use a wheelchair  Use a walking stick  Use a walking frame

Use an invalid carriage  Walk unaided

**How far can you/they walk on the level?**

Not at all  Only around the home  Walk unaided a short distance (*how many yards/metres?*)

**How many stairs can you/they manage?**

None  In the last year up to one flight (approx 12 stairs)  More than one flight

**Are you awaiting any operation or investigations?** YES  NO

**If YES, please give details:**

.....  
.....



(B) **SECTION TO BE COMPLETED BY THE APPLICANT IN RESPECT OF HIS/HER ILLNESS AND/OR THAT OF HIS/ HER CHILDREN UNDER 16**

I authorise the disclosure of my medical history (and that of my children) to the Council's Medical Advisor. I declare that this information is correct and true, and understand that otherwise I may be expected to pay for the cost of any medical report the Council obtains.

Name of Doctor: .....

Address of Doctor: .....

Date: ..... Signature:.....

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(C) **SECTION TO BE COMPLETED BY OTHER MEMBERS OF THE HOUSEHOLD OVER 16 IN RESPECT OF THEIR ILLNESSES**

I authorise the disclosure of my medical history to the Council's Medical Advisor should this be necessary. I declare that this information is correct and true, and understand that otherwise I may be expected to pay for the cost of any medical report the Council obtains.

Name of Doctor: .....

Address of Doctor: .....

Date: ..... Signature: .....

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**DECLARATION**

I confirm that the information given on this form is correct

I authorise the disclosure of my medical history (and that of my children) to the Council's Medical Advisor

Signature of Person who is ill or disabled: ..... Date: .....  
(if different to the applicant)

Signature of Applicant: ..... Date: .....

Please return this form to:

The Housing Needs Manager, Runnymede Borough Council,  
Civic Offices, Station Road, Addlestone, Surrey KT15 2AH