



5. Do you use a wheelchair?

YES                      NO                      (please circle)

6. Is medication prescribed for your condition?

YES                      NO                      (please circle)

If YES, which medication?

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7. Please give:

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Telephone Number: \_\_\_\_\_

8. Do you have an Occupational Therapist, Social Worker or Specialist?

YES                      NO                      (please circle)

If YES, can you give details (e.g. name, job title, place of work, telephone number)

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9. Please complete for any hospital admission in the last 12 months.

HOSPITAL	DEPARTMENT	SPECIALIST	REASON	DATE

10. Please give details of attendance at clinics or out-patients within the last 12 months.

HOSPITAL	DEPARTMENT	SPECIALIST	REASON	DATE

11. Are any allowances or benefits received because of the medical condition?

YES                      NO                      (please circle)

If YES, please give details.

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12. Are you in receipt of:-

- |     |                             |          |          |
|-----|-----------------------------|----------|----------|
| (a) | Disability/Living Allowance | YES / NO | (circle) |
| (b) | Attendance Allowance        | YES / NO |          |
| (c) | Severe Disability           | YES / NO |          |

13. Are you:-

Confined to bed?	YES / NO	(circle)
Unable to climb any stairs?	YES / NO	
Unable to climb more than one flight of stairs?	YES / NO	
Able to do your own shopping?	YES / NO	

14. Please describe how YOUR PRESENT HOUSE IS UNSUITABLE ON MEDICAL GROUNDS:

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14. Please state what TYPE OF HOUSE YOU ARE SEEKING ON MEDICAL GROUNDS: (e.g. ground floor, or house on a level site, or a larger or smaller house)

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15. The information given in this form is, to the best of my knowledge, correct.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_