

Medical Assessment

This form is to be completed by the client's health care professional to provide information about the client's medical condition. Page 1 is to be completed by the client and the health care professional is to complete page 2 onwards. Please use BLOCK LETTERS and print in black or blue pen only. Please mark all relevant boxes with a . If you need more space, please write on a blank page and attach it to this form. For information or assistance with this form, phone 1300 468 746, 24 hours a day, 7 days a week.

Client reference number

T-File number

Application reference number

Payment reference number

Name of social housing provider

Client details

Title
Mr, Mrs, Ms, Miss

Last name
or family name

First and middle name(s)

Unit/House number

Street/Avenue

Town/Suburb

Postcode

FACS Privacy Notice

This privacy notice applies to the Department of Family and Community Services (the Department). The Department together with its related agencies complies with NSW privacy legislation when collecting and managing personal and health information. The information we collect from you or from an authorised third party will be held by the program that collects it. It will be used to deliver services and to meet our legal responsibilities. We may also use your information within the Department as a whole to plan, coordinate and improve the way we provide services and may exchange your information with other social housing providers for the purpose of assessing your continuing eligibility for social housing and providing an appropriate service. The Department is also legally authorised to disclose information to outside bodies in certain circumstances.

Further information about your privacy rights can be found on the Department's website: www.facs.nsw.gov.au/site_information/privacy or by calling: 02 9377 6000 or by emailing: privacy@facs.nsw.gov.au.

Notice: Your personal information and any relevant health information provided on this form will be exchanged between social housing providers (public, community and Aboriginal housing) for the purpose of assessing your continuing eligibility for social housing and providing an appropriate service.

Authorisation

- I have read and understand the above notice.
- I give permission for medical details affecting my need for housing to be released to the above named social housing provider and, if necessary, for my doctor/health care professional to discuss these details on my behalf with the social housing provider.

Signature

Date

To the health care professional

The client has presented to the social housing provider requesting housing assistance. Social housing providers are committed to allocating suitable housing and creating sustainable tenancies. When completing this form it is important to take into account that information you provide will be most helpful to the client if it reflects your professional opinion. The information you provide will assist in accurately assessing the client's housing need, including particular housing features, such as type or location.

To assist in this process the following information is required.

Details of health care professional completing this form

Title
Mr, Mrs, Ms, Miss, Dr

Last name or family name

Organisation Name

Unit/House number

Street/Avenue

Town/Suburb Postcode

Phone Mobile

Email

Provider number

1. Please describe the professional service you provide to the client.

General practitioner Specialist

Other Allied health worker
↓
give details

2. Please describe your field of expertise.

3. How long has the client been one of your patients?

One consultation only Weeks

Months Years

4. Please provide details of the client's medical condition and the affects it has on both their housing needs and their ability to access and sustain housing.

Name of medical condition(s)

Description of condition(s)

How the condition(s) affects the client's housing needs

Frequency of visits to the practitioner

Overall impact of the condition(s) on the client's wellbeing (please tick)

Minor

Moderate

Severe

5. What is the likely duration of the condition(s)? (please tick)

Short
(0 - 2 years)

Medium
(2 - 5 years)

Long
(5 years or more)

6. Do any of the above medical conditions restrict the client from accessing the required health service by walking or taking public transport?

Yes
↓
give details

No → Go to 7.

7. Is the client's current accommodation exacerbating their medical condition(s)? (e.g. lack of room for specialised medical equipment)

Yes
↓
give details

No → Go to 8.

8. Is the client's mobility restricted?

Yes
↓
give details

No → Go to 9.

9. Can the client manage steps/stairs?

Yes
if yes, how many

No → Go to 10.

1-2

3-5

6 or more

10. Does the client need accommodation that is modified? (e.g. hobless shower, 1/4 turn taps, wheelchair access)

Yes
give details

No → Go to 11.

Text input area for details of modified accommodation.

11. Does the client's condition(s) affect their ability to look for suitable private rental accommodation?

Yes
give details

No → Go to 12.

Text input area for details of condition affecting rental search.

12. Does the client have extra expenses because of their medical condition(s)?

Yes
list the expenses incurred on a regular basis which may cause financial hardship to the client

No → Go to 13.

Text input area for details of extra expenses.

13. Does the client need to live in a particular area to access support services?

Yes
what location is required?

No → Go to 14.

Text input area for location details.

14. Has an independent living skills assessment been done?

Yes
attach the independent living skills assessment

No → Go to 15.



15. Is the client able to live independently without support?

Yes → Go to 16.

No
tick required support

Personal care

Cooking

Shopping

Cleaning

Financial management

Identifying unsafe situations

Other
give details

Transport

Text input area for other support details.

16. Does the client currently have support for these functions?

Yes
name of support person/provider

No → Go to 17.

17. Does the client currently have a carer?

Yes

No → Go to 19.

18. Is the carer (please tick)

Part time

Full time

On a needs basis

18a. Does the carer live with the client?

Yes

No → Go to 19.

19. Do psychological issues affect the client's ability to cope?

Yes

No → Go to 23.

20. Does the condition(s) require medication for the client to live independently?

Yes
give details

No → Go to 21.

21. Is the client's condition(s) supported by other health professionals?

Yes
tick all that apply

No → Go to 22.

Mental health workers

Counsellors

Psychiatrists

Other health professionals
give details

22. Does the client have a particular dwelling requirement as a result of the condition(s)?

Yes
give details

No → Go to 23.

23. Would you like to add further comments to support the client's needs?

Yes
give details

No → Go to checklist.

Checklist

If appropriate, have you attached copies of relevant documentation such as:

Independent living skills assessment

Occupational Therapist's report detailing required modifications

Other documentation

give details



Practitioner's name

Signature

Date

Thank you for taking time to complete this form