

# BRISTOL HOUSING REGISTER

## REHOUSING ON HEALTH GROUNDS ASSESSMENT FORM

Please use this form to tell us about any health or support needs that you or a member of your household may have that relate to your housing. **If there is more than one member of your family that you wish to tell us about please complete a separate form for each person.**

### Details of person with needs

Full Name:  Date of birth:

Current Address:

Telephone Number:

### CONSENT AND DECLARATION *(please tick)*

- I agree to the information given by me on this form being used by Home Choice Bristol to assess my priority for rehousing.
- I agree that Home Choice Bristol can seek additional information from my Doctor, other agencies, or people who provide support, (listed on part 5 of this form) to assist my application for rehousing.
- I agree to the sharing of information that I have given, or that has been given about me, with relevant agencies on a 'need to know' basis and in accordance with Data Protection requirements.

Yes  No

Signature:

Date:

#### OFFICE USE ONLY

Applicants name (If different from above): \_\_\_\_\_ Ref: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

# Part 1: Your current accommodation

- **Current Housing facilities**

Do you live in a: House  Maisonette  Flat  Mobile home

other (describe): \_\_\_\_\_

If you live in a flat which floor do you live on? \_\_\_\_\_

Is there a lift to this floor? Yes  No

How many bedrooms do you have? \_\_\_\_\_

Do you have a separate lounge and dining room? Yes  No

How many toilets are there?. Upstairs  Outside  Downstairs

Do you have a Bath  Shower

Do you have any problems accessing bathroom facilities? Yes  No

If yes what? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- **Do you have any difficulties with stairs?**

Cannot manage at all  Can manage with some difficulties /with help

How many steps are there from the backdoor to the garden? \_\_\_\_\_

How many steps are there from the road to the front door? \_\_\_\_\_

- **Do you have any disrepair problems at your property?** Yes  No

If yes what? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If yes and you are a city council or housing association tenant has this been reported to your landlord or estate management team? Yes  No

- **Do you have any problems with neighbours?** Yes  No

If yes what? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If yes and you are a city council or housing association tenant has this been reported to the city council estate management team or housing association? Yes  No

● **Heating**

What type of heating do you have? \_\_\_\_\_

Which rooms have heating? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your heating adequate for your needs? If not please say why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

● **Parking**

Do you have a disabled parking bay outside you home? Yes  No

If you have any parking problems please describe them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

● **Has your home already been adapted to help you?**

(eg. walk in shower, grab rails, ramps)

Yes

No

If yes please describe the adaptations that have been made: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you on a waiting list for adaptations?

Yes

No

What adaptations are you waiting for? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

● **Storage of medical equipment** (eg. dialysis machine, hoist, oxygen)

Please describe any large items you currently use? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any storage problems? \_\_\_\_\_

\_\_\_\_\_

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## Part 2: Your health problems

- Please describe any current problems with your physical health

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- Please describe any current problems with your mental health

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- Please explain why you feel your current accommodation is unsuitable for your health needs?

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- Do you attend a hospital clinic for any of the above problems? Please say which hospital and consultant you see.

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- Have you been a hospital inpatient in the last 5 years for these problems? Please say where, when and for how long?

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- **Do you receive any care from community health care teams?** (eg district nurse, diabetic nurse, Occupational therapist or mental health services)

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- **Do you currently take any prescribed medication? Please list here or enclose a copy of a prescription summary.**

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**Mobility issues**

- **If you have difficulty walking which of the following do you use?** (tick those that apply)

<input type="checkbox"/> Nothing	<input type="checkbox"/> Walking stick
<input type="checkbox"/> Self Propelled wheelchair	<input type="checkbox"/> Walking frame
<input type="checkbox"/> Motorised wheelchair	<input type="checkbox"/> Electric Scooter

Other (please describe): \_\_\_\_\_

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- **If you use a wheelchair where is it used?** (tick those that apply)

<input type="checkbox"/> Indoors only	<input type="checkbox"/> Both indoors and outdoors
<input type="checkbox"/> Outdoors only	

- **For what distance, or for how many minutes, are you able to walk on the level before you need to rest?** \_\_\_\_\_

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- **Do you have difficulty walking up hills or on a slope?** Yes  No

**Please describe problems in your local area**

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## Part 4: Details of people who currently provide you with help or support *(please complete)*

	<b>Their name &amp; address</b>	<b>Telephone number</b>	<b>How often do you see them?</b>	<b>May we contact them for further information?</b>
<b>Your Doctor</b>				
<b>Hospital Consultant</b>				
<b>Support Worker</b>				
<b>Social Worker</b>				
<b>Home Carer</b>				
<b>District Nurse</b>				
<b>Health Visitor</b>				
<b>Community Nurse</b>				
<b>Psychiatric Nurse</b>				
<b>Occupational Therapist /Aide</b>				
<b>Relative</b>				
<b>Friend</b>				
<b>Other</b>				



