



Date: _____

Ref: _____

COC date: _____

Medical Questionnaire

This form must be used in conjunction with the Application for Medical Priority form, and only requires to be completed when an applicant is not in receipt of a mobility component of Disability Living Allowance.

You should complete this form and take it to your GP who should complete Sections 2 and 3. It should then be returned to SHA, Helen McGregor House, 65 Pettigrew Street, Shettleston, Glasgow G32 7XR.

Please answer all questions using BLOCK CAPITALS and tick (✓) boxes as required.

The information you provide will be treated as STRICTLY CONFIDENTIAL.

If you would like help filling in this form, please do not hesitate to ask.

1. YOUR PERSONAL DETAILS

Surname: _____ Title (Mr, Mrs, Miss, Ms): _____

First names: _____ Date of birth: _____

Address: _____ Flat position: _____

Postcode: _____

Home tel: _____ Mobile tel: _____ Work tel: _____

I authorise my GP to forward any information to Shettleston Housing Association which is considered relevant to my application for housing on the basis that alternative accommodation would benefit my health or that of a member of my household.

Signed: _____ Date: _____

2. MEDICAL CONDITION

THIS SECTION TO BE COMPLETED BY YOUR GP

Please complete this section if you feel that the patient named above has a medical/health condition which would benefit from rehousing.

Please give a diagnosis of the patient's medical condition:

How long has the patient had this/these conditions: _____

Is the condition temporary? ☐ YES ☐ NO

Please detail your explanation: _____

3. HOUSING REQUIREMENTS

THIS SECTION TO BE COMPLETED BY YOUR GP

In your opinion, does the condition mean that the patient has particular housing requirements?

☐

YES

☐

NO

If YES, can you give details:

In your opinion, in what ways are the patient's current housing circumstances affecting their condition?

In your opinion, does the patient require an extra bedroom for a carer?

☐

YES

☐

NO

If YES, please explain why:

In your opinion, do you think your patient would benefit from being rehoused into:

☐

Ground floor accommodation
or

☐

First floor accommodation

Name of GP:

Practice address:

Postcode:

Tel:

GP Address Stamp

Signed:

Date:

Thank you for completing this form



**SHETTLESTON
HOUSING
ASSOCIATION**

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