# Housing Pathways

NSW GOVERNMENT | Communities & Justice

# 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 1800 422 322, 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, Mx

Last name
or family name

First and middle name(s)

Unit/House number

Street/Avenue

Town/Suburb

Postcode

Phone

Mobile

Email address

**DCJ Privacy Notice**

This privacy notice applies to the Department of Communities and Justice (DCJ) which includes the following entities: the Land and Housing Corporation and the Aboriginal Housing Office. DCJ and its related entities comply 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 DCJ or the entity that collects it. It will be used to deliver services and to meet our legal responsibilities. We may also use your information within DCJ as a whole to plan, coordinate and improve the way we provide services. DCJ 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.

**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 DD/MM/YYYY

## 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, Mx, 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 ☐ 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
- ☐ 1-2
- ☐ 3-5
- ☐ 6 or more

☐ No → Go to 10.

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

☐ Yes → Go to 11.

☐ No → Go to 12.

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**11. Is a low or high level of modification required?**

☐ Low: Mainly additions, suitable for a "handy man" e.g. lever taps, grab rails, accessible door handles, painting of door frames or steps to improve visibility

☐ High: Likely to involve alterations and/or building works e.g. alterations to allow access for a wheelchair, or installation of a hoist, full kitchen or bathroom modifications such as changing cupboard heights or removing shower hob and screens

Give details

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

☐ Yes
give details

☐ No → Go to 13.

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**13. 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 14.

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

☐ Yes
what location is required?

☐ No → Go to 15.

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**15. Has an independent living skills assessment been done?**

☐ Yes
attach the independent living skills assessment

☐ No → Go to 16.

**16. Is the client able to live independently without support?**

☐ Yes → Go to 22.

☐ No
tick required support

- ☐ Personal care
- ☐ Cooking
- ☐ Shopping
- ☐ Cleaning
- ☐ Financial management
- ☐ Identifying unsafe situations
- ☐ Other give details
- ☐ Transport

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**17. Does the client currently have support for these functions?**

☐ Yes → Go to 18.

☐ No → Go to 19.

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**18. Who provides this support?**

- ☐ NDIS
- ☐ Carer
- ☐ HASI
- ☐ Other

Name of support person/provider

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**19. Does the client currently have a carer?**

☐ Yes

☐ No → Go to 22.

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**20. Is the carer** (please tick)

- ☐ Part time
- ☐ Full time
- ☐ On a needs basis

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**21. Does the carer live with the client?**

☐ Yes

☐ No → Go to 22.

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

☐ Yes

☐ No → Go to 26.

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

☐ Yes
give details

☐ No → Go to 24.

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

☐ Yes
tick all that apply

- ☐ Mental health workers
- ☐ Counsellors
- ☐ Psychiatrists
- ☐ Other health professionals give details

☐ No → Go to 25.

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

☐ Yes → give details

☐ No → Go to 26.

**26. 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 DD/MM/YYYY

***Thank you for taking time to complete this form***