Government of **Western Australia**
Department of **Housing and Works**

Medical and Disability Information

Purpose

This form is to be completed by a Medical Practitioner when a member of your household has a medical condition or disability that requires consideration by the Department of Housing and Works when assessing:

- Housing needs and requirements
- Eligibility for disability income limits

When completing this form

- Please answer all of the questions

Supplementary forms

- Complete a separate Medical and Disability Information form for **each person** in your household who has a medical condition or disability
- If you have more than one Medical Practitioner providing support for your situation, a Medical and Disability Information form will need to be completed by **each practitioner**
- If property modifications are required, an Occupational Therapist assessment is to accompany this form

How to submit

- Please return the completed form to your closest Housing office where your eligibility will be assessed.

Office use only

Application number _____

Person reference number _____

Received and checked by _____

System updated by _____

Date _____

Date received stamp

Client to complete

Details of person with a medical condition or disability

1. What is this person's name?

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Second Name

Family Name

2. What is this person's gender?

☐ Male ☐ Female

☐ X (indeterminate, intersex or unspecified)

3. What is this person's date of birth?

D D M M Y Y Y Y

4. What is this person's postal address?

Street number or Post office box number

Street Name

Suburb / Town

State

Postcode

5. What is this person's phone number?

Doctor to complete

6. Does the patient have a medical condition or disability which impacts on their housing need?

Yes ☐ No ☐

7. Is the medical condition or disability permanent or likely to be permanent?

Yes ☐ No ☐

8. Is the medical condition or disability chronic or episodic in nature?

Yes ☐ No ☐

Doctor to complete (continued)

9. Is the impact of the medical condition or disability on the wellbeing of the client:

☐ Minor ☐ Moderate ☐ Severe

Please provide details

10. Does the patient use a wheelchair?

Yes ☐

No ☐

Please provide dimensions of wheelchair (for housing allocation purposes)

Is the wheelchair use permanent or likely to be permanent in the future?

Yes ☐ No ☐

11. Please specify the nature of this patient's medical condition or disability.

☐ Physical
- ☐ Lower limbs
- ☐ Upper limbs
- ☐ Spinal
- ☐ Multiple

☐ Neurological
- ☐ Psychiatric
- ☐ Cognitive
- ☐ Chronic Illness

☐ Sensory
- ☐ Hearing impaired
- ☐ Sight impaired
- ☐ Bellman Smoke Alarm required

☐ Intellectual
- ☐ High support needs
- ☐ Low support needs

12. Does the patient's medical condition or disability impact on the following housing needs?

a. Housing design, property type or requirements? This includes:
i) Property modifications to kitchen, bathroom and/or toilet
ii) Support animals, yard requirements (fenced and sizing)
iii) Requirement of no stairs or steps
iv) The need for ongoing support services
v) Changes to handles/power-points/light switches

Yes ☐ No ☐

Please provide details

b. Amenity level. This includes: i) Circumstances where an additional bedroom is required for the provision of a live in carer or a co-resident carer

Yes ☐ No ☐

Please provide details

Doctor to complete (continued)

c. Proximity to medical and support services.

This is only applicable where: i) The patient is required to frequently access the service

Yes ☐ No ☐ ii) The service is not readily available where the patient is currently living

Please provide details iii) The patient cannot easily travel to the service

12. Is the patient's medical condition or disability caused or aggravated by their current housing situation?

Yes ☐ No ☐

Please provide details

13. Is the patient's current housing situation overcrowded and impacting on their health and wellbeing?

Yes ☐ No ☐

Please provide details

Doctor to complete (continued)

Engagement with the Department of Housing and Works

14. Does the patient have legal capacity to sign relevant legal documentation?

Yes ☐ No ☐

Please provide details

15. Further comments

Medical Practitioner Declaration

I declare that the information provided in this form is true and accurate.

Name of Doctor

Name of Practice

Address of Practice

Doctors Registration Number

Practice Stamp

Contact Number

Signature

Date

D D M M Y Y Y Y