**THE CYRIL WOOD MEMORIAL TRUST**

FAULKNER HOUSE, 31 WEST STREET, WIMBORNE, DORSET BH21 1JS

Tel: 01202 842689

**MEDICAL ASSESSMENT FORM**

**(To be completed by a Registered Health Practitioner)**

*Please answer each question fully*

**Patients Name(s) & Date of Birth:**

**Present Address:**

**Details of medical condition/s:**

**Is the condition:**

**Temporary 🞎 Permanent 🞎**

**Please give details**

**Details of Treatment being received:**

**In what way does the patient’s current housing affect their medical condition?** *(please indicate the severity of the housing situation )*

**Does the patient have problems walking up and down stairs?**

**Yes 🞎 No 🞎**

**Please give details:**

**Does the patient have, or require a carer:**

**Yes 🞎 No 🞎**

**Please give details:**

**If moved how would the patients health improve?**

**Is the patient registered disabled?**

**Yes 🞎 No 🞎**

**Please give details:**

**Does the patient suffer with any phobias? (*If yes please give details of symptoms and treatments)***

**Yes 🞎 No 🞎**

**Please provide any details of support services that the patient receives *(ie CMHT/Social Worker/OT etc)*:**

**Any other comments regarding the patient?**

**GP/consultant/health practitioner details:**

**Name:**

**Position held:**

**Office Address:**

**Signed:**

**Date:**

**Official Practice Stamp:**