

# Confidential Medical Report from treating doctor

(for example a General Practitioner, Psychiatrist or other specialist)

Patient's Name

Date of Birth

Are you his/her usual medical practitioner?

Yes  No

How long have you known this person?

When did you last see this person?

Is there any information in this report which, if released to the person, might be detrimental to his/her physical or mental health?

Yes  No

*(If yes, please identify the information and state why this should not be released directly to the applicant)*


Please list major physical, psychiatric and intellectual conditions, relevant to the person's request for housing. Please include diagnosis, summary of the history, treatment and how the diagnosis was made.

**Condition 1.**


**Condition 2.**


**Condition 3.**


Please indicate whether the patient's condition is:

- Permanent                       Temporary                       Improving  
 Stable                               Deteriorating

Please list any other relevant conditions


Please list all current medication/s being prescribed on a continuing basis


If known, how many times has the patient been hospitalized for the listed conditions in the last five years?     Nil                       1                       2                       3                       4 or more

Has the patient been assessed for community services in the last twelve months? (e.g. Aged Care, Mental Health Team, Occupational Therapist)                      Yes  No

If yes, by whom and what was the major recommendation?


What home support services are currently used?

- Accommodation Support Meeting                       Domiciliary/Community Nurse  
 Nil     Home Help  
 Home Dialysis     Oxygen  
 Meals on Wheels     Other (please specify) e.g. family/friends

If known, please comment on aspects of the person's current accommodation which adversely affects his/her health. (e.g. physical access to present accommodation, distance from support services)


Would a change in the person's housing/location significantly improve his/her:

a) Medical Condition.                      Yes  No  Uncertain  If yes, in what way?


b) Overall capacity to function?    Yes  No  Uncertain  If yes, in what way?


**Please use block letters**

Name:	<input type="text"/>	
Qualifications:	<input type="text"/>	
Address:	<input type="text"/>	
	<input type="text"/>	
Phone:	<input type="text"/>	Fax: <input type="text"/>
Email:	<input type="text"/>	
Signature:	<input type="text"/>	
Date:	<input type="text" value="/ /"/>	
Stamp:	<input type="text"/>	

**Personal Information Privacy Notice**

The Department of Housing is collecting personal information on this form to provide its client with housing assistance. This is authorised by the *Housing Act 2003*. To assist its client with their housing needs and services, relevant personal information may, in very limited and specific circumstances, be disclosed to: Partner agencies, Service providers, Agencies authorised by legislative provisions, and local governments and non-governmental agencies that now, or will, provide them with housing and/or support services. Limited personal information may be used for housing related research, policy or planning functions. Unless authorised or required by law, the personal information contained in this form will not be passed on to any other third party without the client's consent. More information about the department's privacy policy is available on our website at: [www.housing.qld.gov.au/footer/privacy.htm](http://www.housing.qld.gov.au/footer/privacy.htm).