The Finchley Charities

41A Wilmot Close,
East Finchley, London N2 8HP

Tel: 020 8346 9464

email: info@thefinchleycharities.org
www.thefinchleycharities.org

Medical Information Form
for Sheltered Housing for appointment as a resident

This form must be completed by applicant's doctor and not the applicant.

Applicant's contact details

Full Name: (Print name in capitals) Mr/Mrs/Ms/Miss	
Home Telephone No:	Work Telephone No:
Mobile Telephone No:	Email:
Address:	
	Postcode:
Date of Birth:	

GP contact details

Full Name (Print name in capitals) Mr / Mrs / Ms / Miss:	
Practice:	Email:
Address:	
	Postcode:

Medical details

Is the named person prone to falls?

☐ Yes ☐ No

If yes, please give details:

Does the named person have a sensory impairment:

☐ Yes ☐ No

If yes, please give details including mobility issues:

Please indicate the nature of the health condition(s)/problem(s) for the person:

☐ Arthritis/ Stiff Joints	☐ Asthma	☐ Cancer	☐ Diabetes
☐ Cerebral Palsy	☐ Depression/Anxiety	☐ Drug/ Alcohol addiction	☐ Epilepsy
☐ Heart Disease	☐ HIV/Aids	☐ Lung Disease	☐ M E
☐ Mental health condition	☐ Multiple Sclerosis	☐ Parkinson's Disease	☐ Phobia(s)
☐ Stroke	☐ Dementia/Alxheimers	☐ Other, please specify in box below:	

Please provide further details of condition(s)/problem(s) indicated, and how the applicant's current housing is effecting their health:

Are there any other health concerns that you feel we should be aware of?

Please list any acute admissions within the last 3 years:

Hospital	Reason for admission	Dates	Length of stay

Please attach summary record of patient's medical history path, including medication.

Please sign this section

Data Protection Statement

The Finchley Charities will comply with existing and any subsequent data protection legislation and will only process an applicant's personal data as outlined in the Fair Processing Notice for Applicants. By signing this form you are confirming that you have received a copy of the Fair Processing Notice for Applicants.

Applicant's Name:	
Applicant's Signature:	Date:
Doctor's Name:	
Doctor's Signature:	Date:
Practice stamp:	

Summary of applicant's medical history path and medication included:

☐ Yes ☐ No

Please return completed medical form to:

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