

ASSESSMENT REQUEST FORM

**DISABLED FACILITIES GRANT – HOUSING GRANTS, CONSTRUCTION
AND REGENERATION ACT 1996.**

FULL NAME:.....DATE OF BIRTH:.....

ADDRESS:.....

.....POST CODE:.....

TEL NO:..... MR/MRS/MISS (please delete)

DOCTOR'S
DETAILS:.....

.....

NATURE OF
DISABILITY:.....

.....

.....

ADAPTATION
REQUESTED:.....

.....

Contact details (If different from above): Name:.....

Tel No:

Are you on Income Support? YES/NO

(If you require major adaptations and are not on Income Support West Lindsey District Council will need to carry out a financial assessment as part of your grant application. They will contact you concerning this).

Signed:..... Date:.....

**PLEASE RETURN THE COMPLETED FORM TO MRS DI THORLEY AT ACIS
GROUP LTD, ACIS HOUSE, BRIDGE STREET, GAINSBOROUGH, LINCS, DN21
1GG.**

Referral information for an Occupational Therapist assessment request

MR/MRS/MISS

DATE OF BIRTH

FIRST NAME

SURNAME

TELEPHONE NO.

ADDRESS

DO YOU LIVE ALONE Yes/No

IF NO WHO LIVES WITH YOU - Wife/Husband/Partner/child

IS ANY OF ABOVE YOUR FULL TIME CARER

NEXT OF KIN eg name,address,phone no. dob.

YOUR DR'S DETAILS

MEDICAL CONDITION

RELIGION

ETHNIC ORIGIN

ADAPTATION REQUESTED

WHAT TYPE OF PROPERTY DO YOU LIVE IN house/bungalow/flat

IS THE PROPERTY SHELTERED ACCOMMODATION

DO YOU WALK WITH STICKS/WALKING FRAME

HOW FAR CAN YOU WALK

CAN YOU GET IN/OUT OF BED/CHAIR OK or with help

CAN YOU MANAGE TO GET ON/OFF THE TOILET OK or with help

CAN YOU MANAGE TO DRESS/WASH YOURSELF or with help

CAN YOU GET IN/OUT OF THE BATH yes/no or with help

DO YOU DO YOUR OWN COOKING/CLEANING/SHOPPING or with help

HAVE YOU RECENTLY HAD A FALL ?