DOCTOR'S STATEMENT IN SUPPORT OF APPLICATION FOR ELDERLY PERSONS HOUSING

Send To: **Western Bay of Plenty District Council**
Private Bag 12803
Tauranga Mail Centre
Tauranga 3143

Phone 07 571-8008

The information contained in this form is requested for the sole purpose of determining whether the applicant should be granted a tenancy in a WBOPDC Elderly Persons Unit and will not be used for any other purpose.

I ....give consent to my Doctor supplying the information as required below.

Signature.. **Date...**

DOCTOR TO COMPLETE:

Patient Name: ____

Address: ____

Date of Birth: __________________ **Length of time as your patient:** __________________

1. PAST MEDICAL HISTORY / PRESENT MEDICAL HISTORY (including psychiatric history)

Has the patient ever suffered from / is suffering from: **(Please give full details)**

Stroke: ____

Heart Disease or Conditions: ____

Respiratory Disease: ____

Psychiatric or nervous disorders: ____

(please indicate type of illness/disorder) ____

Arthritis: ____

Osteoporosis: ____

Diabetes: ____

Alcoholism: ____

Further Comments:

____

____

Failure to complete this information may lead to your application being refused

2. ASSESSMENT OF:

Mental Condition:

____

____

Degree of Mobility / Type of Disability

____

____

The patient's physical and mental ability to live in unsupervised accommodation and cope on his/her own.

____

____

____

Suitability for high density living. Please confirm that a placement would not lead to disturbance or friction with others.

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Any condition that may affect this person's ability to live alone. (This could include issues such as heavy Drinking or behavioral issues)

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____

Are Support Services Required?

	Current	**Needed**
District Nurse		
Psychiatric Support		
Home Care-Givers		
Other		

	Current	**Needed**
Meals On Wheels		
Home - Help		

Smoker ☐ **Non Smoker** ☐

Doctor's Name & Surgery Address: ____

____ **Phone:** __________________

Signature: ____ **Date:** __________________