Part 3 of HMD-Form 1



Healthcare Professional (B)

NOTE: Please type this form when completing, but if writing you must use block capitals to ensure legibility.

This section must be completed by a Healthcare Professional.

Details of Healthcare Professional	completing	this form:
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First name	Surname
Name of Organisation	Occupation
Registration Number	Email
Telephone	
Please identify the person to whom you are providi	ing professional healthcare services:
First name	Surname
PPS number	Date of Birth
Please indicate the professional service you provide medical condition, and the duration of time they have	
Duration	



Current Accommodation

In your professional opinion, is the accommodation in which the person is residing impacting negatively upon the person's disability or medical condition?
Yes No
If yes, please explain below, and indicate whether you have visited their current accommodation:
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Accommodation Needs
Based upon the information outlined above, in your professional opinion, how would moving to other accommodation meet the accommodation needs of the disabled person or person with a medical condition? Considerations for this may include:
• Location (e.g., Proximity to amenities and services)
 Type of housing (e.g., Wheelchair liveable, wheelchair accessible, level access accommodation, standard accommodation)
 Design of housing (e.g., Accessibility features or other specific features, including additional bedrooms)
Please detail below:



Support Needs of the Applicant

Are supports currently needed to enable the disabled person or person with a medical condition to live independently?
Yes No
If yes, please provide details of support care package below:
Will the disabled person or person with a medical condition need any additional or new supports? Please provide details of the services you envisage will provide those supports.
Yes No
Please provide details below:



Healthcare Professional Declaration

I declare that the information and details I have provided on this form are correct and true.

I agree to the local authority contacting me, if necessary, to verify the details I have provided.

Signature

Date

Please provide stamp from your service below if available:

If you require extra space to complete the form, please include additional pages.