

Accommodation Services Medical Evidence Form

Part A: About You

To be completed by the student before forwarding to GP/medical practitioner.

Full Name:

Phone number:

Student ID or UCAS number:

Part B: Your Medical Condition

Tick all that apply:

Autistic Spectrum Disorder

Blind/partially sighted

Deaf/hearing impairment

Learning difficulty eg Dyslexia

Mental health difficulties

Multiple disabilities

Personal care support

Unseen disability eg diabetes, epilepsy

Wheelchair user/ mobility difficulties

Not Known

Not listed, please state: _____

Please provide any additional information about your disability or medical condition that you feel is relevant:

Please describe how your disability or medical condition affects your accommodation.
Please provide as much detail as possible.

Part C: Healthcare Professional Information

Part C should be completed by the GP or Consultant that you have seen for your medical condition.

Please note, you must provide the full name and address of your GP and/or consultant. A practice or department stamp is also required. Failure to provide these may result in a delay.

Full Name:

Surgery/Department:

Medical practice or departmental stamp:

Signed: _____

Date: _____

Please provide details of the students diagnosis:

Diagnosis: _____

Date of diagnosis: _____ Date of last consultation: _____

Please indicate which of the below are **essential/desirable** in order for the student to manage their medical condition in university accommodation:

	Essential	Desirable		Essential	Desirable
En suite bathroom	<input type="checkbox"/>	<input type="checkbox"/>	Close to University	<input type="checkbox"/>	<input type="checkbox"/>
Ground floor room	<input type="checkbox"/>	<input type="checkbox"/>	Self-contained accommodation	<input type="checkbox"/>	<input type="checkbox"/>
Lift access	<input type="checkbox"/>	<input type="checkbox"/>			

Does your patient require any of the following (tick all that apply):

- | | | | |
|--------------------------|---------------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | Level-access bathroom | <input type="checkbox"/> | Motorised door opening |
| <input type="checkbox"/> | Shower chair | <input type="checkbox"/> | Wheelchair accessible |
| <input type="checkbox"/> | Grab rails | <input type="checkbox"/> | Motorised scooter user |
| <input type="checkbox"/> | Clos-o-mat (WC) | <input type="checkbox"/> | Hoist |
| <input type="checkbox"/> | Profiling height-adjustable bed | <input type="checkbox"/> | Adapted kitchen facilities |
| <input type="checkbox"/> | Fridge for medication | <input type="checkbox"/> | Induction loop |
| <input type="checkbox"/> | Flashing light fire alarm | <input type="checkbox"/> | Vibrating pillow |
| <input type="checkbox"/> | Flashing doorbell | <input type="checkbox"/> | Room for a carer/support worker |

Please provide an additional supporting statement detailing why the student would benefit from the facilities selected in Part C:

Part D: Your Consent

To be completed by the student before submitting to Accommodation Services.

Any information you have provided will be treated in the strictest confidence. Accommodation Services will retain your information for one year, or until you depart our accommodation, whichever is soonest.

It may be necessary to consult with the University's Student Health and Wellbeing Team when processing your application. If you consent to share, the Student Health and Wellbeing Team may contact you about further support and adjustments available to you.

Please indicate your consent below:

I consent for you to share this information with Student Health and Wellbeing

I **do not** consent for you to share this information with Student Health and Wellbeing

Our accommodation guarantee includes managed-partnership residences. **If you're allocated one of these rooms**, we may need to share your details with the provider that manages the accommodation. Your information will be treated with the strictest confidence.

If you do not provide consent to share, we cannot guarantee that your accommodation requirements will be met by the provider.

Please indicate your consent below:

I consent for you to share this information with a managed partner provider

I **do not** consent for you to share this information with a managed partner provider

Please complete and return all pages of this medical evidence form. If you do not give us all the information we need there may be a delay processing your evidence.