

Confidential medical certificate

To be completed by your doctor

Patient Details

Full name:

Date of birth:

Current physical
address:

Please comment on:

Physical and mental condition and ability to cope with living on his/her own:

Suitability for high density living (*need to ensure placement would not lead to disturbance or friction with other tenants - may include heavy drinking, violent or threatening behaviour towards others*):

Degree of mobility:

Any condition that could affect this person's ability to live alone?

Name of Doctor:

Phone:

Address:

Signed:

Dated: