

# Request for Occupational Therapist Assessment for Disabled Adaptations



## Applicant Details

Title: Mr  Mrs  Ms  Miss

Name:

Date of birth:

Address:

Postcode:

Telephone number:

Mobile no:

Name of alternative contact:

Relationship with applicant:

Address:

Postcode:

Telephone number:

Mobile no:

## Brief Description of Difficulties

Please list all medical conditions:

Name of doctor and surgery:

Do you live alone: Yes  No

Do you use walking frames/sticks: Yes  No

(If yes, please state what you use)

What adaptation are you requesting:  
(i.e. Level access shower, stair lift, grab rails, etc)

Signed:

Date:

Print name:

Please forward this form directly to:

**The Access Team  
Penwinnick House  
Trehiddle Lane  
St Austell  
PL25 5BZ**

Ref: AF-A-09

**Telephone: 01872 326600/01872 326613  
Alternatively you can call: 0300 1234131**