ACROSS
St Mark's Community Centre,
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ACROSS
travel for those needing special care

SICK/DISABLED PERSONS Application Form

CONFIDENTIAL

Please print clearly in BLACK INK

Group No

Title			Surname		
First Name			Known As (if appropriate)		
Address					
Town			Post Code		
Date of Birth			Weight		
It is important that all of our groups have a balanced team of helpers & VIP's, which is why we ask for your date of birth here					
Contact Details	Home No:		Work No:		
	Mobile No:		E-mail:		
Passport	Passport No:		Expiry Date:		
Nationality		Do you require a VISA to Travel?	Yes / No		
EHIC Card	Expiry Date:				
Do you intend taking out ACROSS Insurance ?			YES / NO		
If NO above please confirm your Insurance Provider					
Insurance Policy No			Valid From – Until		
Do you have someone accompanying you ?	Y / N	Are they?	A Nurse / A Doctor / A Helper		
If YES above, the person must fill out a separate form. Please give their name and address here;					
When are you available to travel (dates or Group Number)?					
Can you travel at short notice?	Y / N	How much notice do you require ?			
Have you travelled to Lourdes before?	Y / N	With ACROSS	Y / N		
Person to Contact in case of Emergency (*not someone who is travelling with you*)					
Name					
Relationship					
Address					
Town			Post Code		
Contact Details	Home No:		Work No:		
	Mobile No:		E-mail:		
GP Details					
Name					
Address					
Post Code		Tel No			

PLEASE ANSWER FULLY ALL QUESTIONS BELOW, THIS WILL HELP US TO MEET YOUR NEEDS APPROPRIATELY

MOBILITY	Yes or No		
Are you able to stand?		If yes for how long?	
Are you able to walk?		If yes how far?	
Do you use a walking aid?		What type, e.g. Stick, Rollator, Zimmer.. ?	
Can you sit for long periods?		Are you confined to a bed?	
Do you use a wheelchair?		Can you bring it with you?	
Is your wheelchair collapsible?		Can you climb stairs?	
Do you require a hoist to transfer?		**FULL BODY HOIST / ELECTRIC STAND AID**	

IF YOU USE A HOIST or ELECTRIC STAND AID PLEASE BRING YOUR OWN SLINGS WITH YOU

PERSONAL HYGIENE

Do you need help washing?		Do you need help dressing?	
Do you need a shower chair?			

COMMUNICATION

Do you have any difficulty speaking?		If yes what problems?	
Do you use any communication aid, e.g. light writer, book etc. If YES please specify here:			
Hearing *(please tick)*	Normal	Restricted	Hearing Aid
Vision *(please tick)*	Normal	Restricted – Glasses	Registered Blind

BOWEL/BLADDER

Are you incontinent?	Bowel?		Bladder?	
Do you need help at the toilet?		If YES what help?		
Do you have a catheter or use a uro-sheath?		Do you need help with this?		

PLEASE BRING OWN 12 DAY SUPPLY OF PADS/CATHETERS/CATHETER BAGS/UROSHEATH etc.

EATING & DRINKING

Are you on a special diet?		If yes please give details on page 3	
Do you need help to eat?		Do you need help to drink?	
Do you use any equipment at meals?		If yes what?	
Do you have a feeding tube?		If yes which kind?	

PLEASE BRING ANY SPECIAL CUTLERY OR DRINKING AIDS WITH YOU

BREATHING

Do you get breathless easily?		Do you use Inhalers/ Nebuliser?	
Do you require Oxygen (even occasionally)?		If yes for how long each day?	
If you use Oxygen, how many litres per minute?			
Anyone who uses oxygen will be sent a separate form to complete and return to the office			

PLEASE BRING YOUR OWN MASKS AND TUBING IF USING OXYGEN

NIGHT CARE

Do you need help during the night?		Do you need to sleep upright?	
If yes, please specify			

SKIN INTEGRITY

Do you have any wounds?		If yes how often are the dressings changed?
Do you use any creams regularly?		Which ones and to where?
Telephone number of your District / Practice Nurse:		

DO YOU ROUTINELY USE ANY OF THE EQUIPMENT LISTED BELOW?

	Yes / No		Yes / No
Commode		Urinal	
Bedpan		Bedrails	
Banana Board		Raised Toilet Seat	
Slide Sheet		Turntable	
Special Mattress		Which type?	
If it is an Electric Pressure Mattress could you bring it for use in Lourdes?			
Please specify any other equipment used:			

MEDICATION

Do you Self-Medicate or		Require Supervision?	

Do you have any KNOWN ALLERGIES? Yes / No If **YES,** please specify here;	
Do you have an ADVANCED HEALTH CARE DIRECTIVE	Yes / No

Please list all medications, injections, enemas, suppositories etc. that you use regularly or preferably <u>provide a copy of your repeat prescription</u> **YOU MUST BRING 12 DAYS SUPPLY OF ALL MEDICATION IN YOUR HAND LUGGAGE**

ADDITIONALLY - IF YOU HAVE A CARE PLAN PLEASE LET US HAVE A COPY

FURTHER INFORMATION

To help us to make your pilgrimage more comfortable, please indicate any specific dietary requirements, (e.g. vegetarian, Gluten free). The hotel serves a set menu of meals each week, which may include veal and fish. The staff are helpful in accommodating special diets but need to know in advance. If you have special dietary needs including food allergies, please note them here. If you are on a special diet and need specific food or drink, please bring some with you both for the journey and the hotel.

PERSON TO WHOM CORRESPONDENCE SHOULD BE SENT (IF DIFFERENT FROM HOME ADDRESS GIVEN)

Full Name			Surname	
Address				
Town			Post Code	
Contact Details	Home No:		Work No:	
	Mobile No:		E-mail:	

If this application is successful and I am allocated a place on a pilgrimage to Lourdes, I understand that the information provided by me and my doctor WILL be conveyed in the strictest confidence to those who will be responsible for my care, when necessary this may include carers that have no medical or nursing qualifications. Should you wish any of the information to be restricted to medical/nursing personnel only, please advise the Group Organiser at the ACROSS Office prior to departure, or to the group nurse/doctor accompanying you.

I agree / do not agree that any photo taken of me whilst on pilgrimage may be used to promote the work of ACROSS both in printed and online format.

THE DETAILS ON THIS FORM ARE CORRECT, I AM AWARE THAT ANY CHANGES MUST BE DISCLOSED TO THE ACROSS OFFICE IMMEDIATELY.

Signature Date

MEDICAL QUESTIONNAIRE

To be completed by your General Practitioner or Hospital Consultant

PLEASE PRINT CLEARLY AS THIS FORM HAS TO BE PROCESSED BY OUR ADMINISTRATION OFFICE AND MEDICAL TEAM

Patient's Name	Date of Birth
Patient's Address	
Date last seen	Estimated Weight
Current Relevant Conditions / Diagnosis (including complications)	
Is your patient aware of his/her diagnosis? YES / NO	

Is a DNACPR policy in place? YES / NO **If YES please attach relevant documentation**
(which will be returned to you)

Past Medical History and or Operations	
Current Medication and Treatments **PLEASE ENCLOSE A CURRENT COMPUTER PRINTOUT**	
Drug Sensitivities or Allergies	Date of Tetanus Immunization
Are there any Cardiac / Respiratory problems	
Are there any problems with the Genito-Urinary System	
Is there a history of Mental Illness (if yes please give details) *(Date of last admission to hospital & contact details for CPN if applicable)*	
Is there a history of Seizures (if yes please give details and date of last seizure)	
CNS including Sight, Hearing, Speech	
Is there a history of Alcohol/Drug Misuse? (Essential for insurance cover)	
MRSA, should your patient require hospitalisation during their trip, it is important that we can provide as much information as possible, can you confirm what their status is, and if positive where is the source.	
POSITIVE NEGATIVE	UNKNOWN

We always have at least one registered nurse on board each vehicle

BLOCK CAPITALS OR STAMP PLEASE	
Name/Address & Telephone Number of Doctor or Consultant Name & Hospital	
Doctor's or Consultant's Signature	**Date**