

SECTION 5 – All clients should complete this section

We need to know the following information for people with cancer and for supporters.

Are you supporting someone with a cancer diagnosis? Yes No

If YES, please give their name _____

Has the person you are supporting used our services previously? Yes No

About You

Date of birth:	Age:	Ethnic origin:
Occupation/previous occupation:		Faith/spiritual belief:
Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>		Have you smoked in the past? Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, when did you quit?		

Your Health

Please tell us about any current medical problems or symptoms you are experiencing (apart from the cancer diagnosis).

Please tell us about your medical history. Please include previous surgery, trauma or accidents, chronic conditions, allergies and heart problems.

Please tell us about any mental health problems or mental illness you may have suffered.

Please list any medication you are currently taking, including herbs, homeopathic remedies and vitamin/mineral supplements.

Medication	Dose	Frequency	Medication	Dose	Frequency

Booking Form



Please complete this form and return it to Penny Brohn Cancer Care, Chapel Pill Lane, Pill, Bristol BS20 0HH. It is important that people with a cancer diagnosis and their supporters who will be using the service both complete separate copies of this form.

SECTION 1 – All clients should complete this section

What service are you booking? Please tick

Bristol Approach (2 day) <input type="checkbox"/> Bristol Retreat (5 day) <input type="checkbox"/> Mini Retreat for the Spirit (2 day) <input type="checkbox"/>	Single Day Course <input type="checkbox"/> Please provide details below Cancerpoint <input type="checkbox"/> Please provide details below _____
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If you have booked a course provisionally, please tell us the date / /

Have you used Penny Brohn Cancer Care or Bristol Cancer Help Centre services before?
 Yes No If yes, which? _____ when? _____

Personal Details - Confidential

Name:	Title:
Address:	Postcode:
	Home Tel:
	Daytime Tel:
Email:	Mobile:

How would you like us to contact you? Please tick

Mail Email Telephone Mobile May we leave a message? Yes No

Emergency Contact Details

Name:	Relationship to you:
Address: (if different from above)	Postcode:
	Daytime Tel:
	Mobile:

Your Medical Team

GP:	Oncologist:
Practice:	Surgeon:
	Hospital:
Telephone:	Telephone:
May we contact them? Yes <input type="checkbox"/> No <input type="checkbox"/>	May we contact them? Yes <input type="checkbox"/> No <input type="checkbox"/>

How did you hear about Penny Brohn Cancer Care? Medical Team Family/Friend

Website Media Article MacMillan Nurse Former Service User Support Group
 General Awareness Other _____

Data Protection: We would like to keep you updated about the work of Penny Brohn Cancer Care and its subsidiaries. Please tick the box if you would prefer NOT to receive this information by post by email . Penny Brohn Cancer Care respects your privacy. All the data we hold are gathered and managed in strict accordance with the Data Protection Act (1998). We will not disclose any information supplied by you to any third party without your permission.

I confirm that I have read and understood the Terms and Conditions.

Signature _____ Date _____

SECTION 2 – Please complete this section if you are booking a Residential Course (Cancerpoint clients, please turn to SECTION 4 on the next page)

Are you well enough to come to the Centre at the moment? Please answer the following questions to help decide if this is the right time for you to come on a course.

	YES	NO
Are you in a lot of pain, or on pain medication that affects your concentration?		
Do you require more than 2 hours rest during the day?		
Do you have a low blood count which may put you at risk of infection?		
Do you have an infection or infectious illness that may put others at risk?		
Do you ever suffer from epileptic or other fits?		
Would it be difficult for you to cope with hotel type accommodation?		
Do you have a colostomy/ileostomy/urostomy? (please circle)		
Do you need specialist nursing or medical care – eg injections, dressings?		
Please tell us about any problems you may have with accessing our services, eg sensory impairment, mobility problems:		

If you answered YES to any of the above, you may still be able to attend. We will contact you by phone to talk things through before confirming your booking.

SECTION 3 – Please complete this section if you are booking a Residential or a Single Day Course

Diet

Penny Brohn Cancer Care serves organic whole food, in line with our Healthy Eating Guidelines; some meals include white meat, fish or eggs.

Are you following a particular way of eating? **Please tick**

Vegetarian diet <input type="checkbox"/>	Vegan diet <input type="checkbox"/>	Raw food only diet <input type="checkbox"/>	Neutropenic diet <input type="checkbox"/>	Low residue diet <input type="checkbox"/>
Calorie dense diet <input type="checkbox"/>	Liquid diet <input type="checkbox"/>	Other (please give details) <input type="checkbox"/>		

Can you eat the following foods – please tick all that you can eat:

Raw vegetables and fruit <input type="checkbox"/>	Cooked vegetables and fruit <input type="checkbox"/>	Whole grains <input type="checkbox"/>	Nuts and seeds <input type="checkbox"/>
Pulses (peas, beans, lentils) <input type="checkbox"/>		Animal products (white meat, fish, eggs) <input type="checkbox"/>	
Do you have difficulty chewing or swallowing solid food? Please give details:			
Are you allergic or intolerant to any foods? Please specify which and give details:			

Payment

Penny Brohn Cancer Care makes every effort to make its services accessible to all. Please refer to the enclosed fees sheet for details of costs and of the Access Fund scheme.

Please tick the boxes below to indicate what you are paying for:

I am attending as a:	Person with Cancer <input type="checkbox"/>	Supporter <input type="checkbox"/>
I would like to pay for a:	Bristol Approach (2 day) <input type="checkbox"/>	Mini Retreat for the Spirit (2 day) <input type="checkbox"/>
	Bristol Retreat (5 day) <input type="checkbox"/>	Single Day Course <input type="checkbox"/>

I enclose a cheque for £ _____ (payable to Penny Brohn Cancer Care)

Please debit my Visa / Mastercard / Switch / Delta / Maestro (please circle) Amount £ _____

Card Number

Start date / End date / **We will telephone to ask for your security code**

Signature _____ Date _____

SECTION 4 – Please complete this section if you have a current or past diagnosis of cancer (Supporters without a previous diagnosis please turn to SECTION 5)

Cancer History

Date/s of Diagnosis	Site/s of Primary Cancer	What treatment have you had, or is planned?	Dates of treatment
Is the tumour hormone sensitive? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>			

Do you have secondary cancer?

Date/s of Diagnosis	Site/s of Secondary Cancer	What treatment have you had, or is planned?	Dates of treatment

Please tell us about any symptoms or side effects from treatment

Is there anything you would like us to know about your cancer diagnosis or treatment?