

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 (3 day)
- Bristol Retreat (5 day)
- Mini Retreat for the Spirit (2 day)

- Living Well Course
- Single Day Course
- Cancerpoint
- Open Programme

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 (most recent)? _____

Are you supporting someone on this course who has a cancer diagnosis? Yes No

If YES, please give their name _____

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

About You

Date of birth:	Age:	Ethnic origin:
Occupation/previous occupation:		Faith/spiritual belief:

Emergency Contact Details

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

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 of service at Penny Brohn Cancer Care.

Signature _____ Date _____

SECTION 2 – Please complete this section if you have a current or past diagnosis of cancer

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 No Don't know

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

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"/>

SECTION 3 – All clients should complete this section

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, heart problems, and any other health issues.

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

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

Medication	Dose	Frequency	Medication	Dose	Frequency

Are you well enough to stay at the Centre overnight? Please answer the following questions if you are booking on a residential course (eg Bristol Approach, Bristol Retreat, Mini Retreat for Spirit, Open Programme, Foods to Nourish the Body & Soul)

	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 or similar? (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:		

Your 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**

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"/>			

These are the foods we normally serve – 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"/>	Butter <input type="checkbox"/>
Nuts and seeds <input type="checkbox"/>	Pulses (peas, beans, lentils) <input type="checkbox"/>	Chicken <input type="checkbox"/>	Fish <input type="checkbox"/>
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:			

SECTION 4 – Please use this section for any additional information you would like us to know

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 _____

