MEDICAL INFORMATION TO BE COMPLETED BY GENERAL PRACTITIONER
PLEASE ENSURE FORM IS FULLY COMPLETED USING BLACK INK AND SURGERY STAMP IS AFFIXED

****** Alternatively, a SIGNED computer summary detailing diagnosis, significant medical history, repeat medication, allergies and full immunisation history would be acceptable ******

Dear Doctor, please complete this form below in respect of the named child who has been offered the opportunity of a week in Lourdes with HCPT – The Pilgrimage Trust. (N.B. see signed consent on front page).

Name of child:

Date of birth: NHS no:

Diagnosis:

Please note that the following list includes the great majority of diagnoses of disabled children.
You may find it more helpful to circle the relevant words.

- ❖ BEHAVIOURAL/EMOTIONAL/SOCIAL PROBLEMS / HYPERACTIVITY
  LEARNING DIFFICULTIES mild/moderate/severe. AUTISM/ASPERGER'S
- ❖ CYSTIC FIBROSIS _____
- ❖ DIABETES MELLITUS _____
- ❖ NEOPLASTIC DISEASE _____
  CHEMOTHERAPY: current/recent/previous _____
- ❖ IMMUNO COMPROMISED MILD / MODERATE / SEVERE Details _____
- ❖ CONGENITAL / OTHER HEART DISEASE nature of lesion_____fully/partially/not corrected
  CYANOSIS/PULMONARY HYPERTENSION
- ❖ CONNECTIVE TISSUE DISORDERS JUVENILE RHEUMATOID ARTHRITIS /SYSTEMIC LUPUS/OTHER: _____
- ❖ ARE THERE ANY SAFEGUARDING ISSUES FOR THIS CHILD? YES/NO _____
- ❖ DOES CHILD NEED PRESCRIBED OXYGEN? YES/NO _____
- ❖ *- The above conditions will be subject to further enquiry, usually to a hospital specialist.*

EPILEPSY (well/poorly controlled) Type_____ Fit frequency _____
CEREBRAL PALSY: _____
NEURAL TUBE DEFECT: SPINA BIFIDA/ENCEPHALOCOELE/HYDROCEPHALUS:
INTRAVENTRICULAR SHUNT (for any reason) _____Type of valve _____
MUSCULAR DYSTROPHY: DUCHENNE/OTHER
VISUAL IMPAIRMENT: BLIND/PARTIALLY SIGHTED: BILATERAL/UNILATERAL (R) / (L): Cause if known _____
HEARING IMPAIRMENT: DEAFNESS: TOTAL/PARTIAL (R) / (L). COCHLEAR IMPLANT YES / NO _____
CHROMOSOMAL ABNORMALITY SYNDROMES: DOWN'S _____ (associated heart disease - see above)
OTHER _____
ASTHMA (mild/moderate/severe) _____
BLOOD DISORDERS _____
RENAL/ URINARY DISORDERS INFECTION: chronic/recurrent RENAL FAILURE mild/moderate/severe
DIALYSIS/RENAL TRANSPLANT
SKIN DISEASE _____
FEEDING PROBLEMS YES/NO GASTROSTOMY YES/NO PRESCRIBED NUTRITION _____

TREATMENT

Please provide details and date for any drug allergies _____ / intolerances _____
Recent oral steroids YES / NO Date _____ Recent Cytotoxics YES / NO Date _____
Date of most recent tetanus vaccination _____Physiotherapy _____

Please provide a list of all current medication by attaching a copy of a current repeat prescription. Please use this space for any additional observations.

_____
_____
_____

IMMUNISATIONS

☐ DIP/TET/PER ☐ Measles ☐ MMR ☐ HIB ☐ Polio ☐ Meningitis ☐ Others

Your details

Name of Doctor: _____
Signature of Doctor: _____
Date _____ ☎ _____

Surgery stamp

Note from the Chief Medical Officer: As a GP, I know that you are inundated with forms for completion and I am grateful for the information you provide. HCPT – The Pilgrimage Trust is a charity supported by voluntary contribution. If you do feel it is necessary to make a charge for completing this form, please send an invoice to our office in Rugby (address on the bottom of each page of this form) rather than to the parents/carers, stating the full name, address and date of birth of the child. For more information about the Trust visit www.hcpt.org.uk