**SALFORD DIOCESAN PILGRIMAGE**

**TO LOURDES, 2024.**



 **MEDICAL ASSESSMENT FORM**

**FOR ACCUEIL\* PILGRIMS**

**(The diocese will once again use the Hotel Solitude for pilgrims requiring medical and nursing support. The assessment process will remain the same.)**

**CONFIDENTIAL**

For the use of sick pilgrims applying to travel with the

SALFORD DIOCESAN PILGRIMAGE TO LOURDES
Friday July 26th- Thurs Aug 1st 2024

Pilgrim’s name:

**MEDICAL EXAMINATION FORM FOR ACCUEIL PILGRIMS**

This Medical Examination Form is for sick pilgrims who wish to travel with the Salford Diocesan Pilgrimage to Lourdes. Those pilgrims accepted to travel as part of the Diocesan Pilgrimage will travel by air from Manchester airport and will be accommodated in Lourdes in the Hotel Solitude.

The information gathered on this form is necessary so that we may make the pilgrimage to Lourdes as comfortable and rewarding as possible for all our sick pilgrims. All information is kept in strict confidence and shared only with people directly involved in the care of sick pilgrims.

**Please note that submission of this form does not guarantee a place on the pilgrimage. A medical assessment must first be completed- you will be contacted with the details of this. Your place will be confirmed after the assessment unless the medical and nursing team feel we cannot meet your needs, if this is the case it will be discussed with you. If you are provisionally given a place, it is only guaranteed once we ALSO receive your FORM B which states your GP agrees you are fit to travel.**

The **emergency contact** details you provide must be valid for the whole duration of the pilgrimage. It is essential that the named person will be available, for example in the event of the unexpected cancellation of aircraft or other unforeseen eventuality. Where possible, please include a mobile telephone number for your emergency contact.

***Instructions for pilgrims and their carer’s.***

Please complete **SECTION A,** using **BLOCK CAPITALS**. Once complete, **please hand the form to your G.P.** asking them to kindly complete **SECTION B**.

Once the form is complete, please post it directly to the Pilgrimage Office.

All information in these forms is treated in the strictest of confidence.

You will also be requested to attend one of our medical assessment days, where we invite you and your family/carers to meet our medical and nursing team, receive information about your pilgrimage and talk about your medical and care needs during the pilgrimage. Each of the assessment days will be conducted at the Cathedral Centre, 3 Ford Street, Salford, M3 6DP.

Once we have received your application we will be in touch with you with further details. Please note that you **MUST** have returned this form to us prior to attending one of the Pilgrim assessment days at the Cathedral Centre.

**SECTION A**

**To be completed by pilgrim/carer**

(Please complete this form to the best of your knowledge and in BLOCK CAPITALS. If unable to complete this form then assistance can be provided by a carer or family member. This person must be fully aware of all medical conditions and must have suitable authority to sign on behalf of the pilgrim.) The information below must be completed in full unless otherwise stated.

|  |  |
| --- | --- |
| TITLE | Rev / Sr / Mr / Mrs/ Miss /Ms |
| FULL NAME (as on passport) |  |
| KNOWN AS |  |
| ADDRESS (include postcode) |      |
| TELEPHONE NUMBERContact name if different to pilgrim |  |
| AGE (at time of pilgrimage) |  |
| DATE OF BIRTH |  |
| EMAIL ADDRESS if used as a method of contact |  |
| PASSPORT NUMBEREXPIRY DATE |  |
|  |
| GHIC NUMBEREXPIRY DATE |  |
|  |
| RELIGION | *You do not have to state any religious affiliation to be part of the pilgrimage, however, if**applicable, please state your religion below:* |

|  |  |
| --- | --- |
| **EMERGENCY CONTACT NO 1**(Please indicate if we can share medical information with this person in an **emergency**) | Name:Can we share medical details in an emergency YES/NO |
| RELATIONSHIP (to pilgrim) |  |
| ADDRESS |  |
| EMERGENCY CONTACT NUMBER |  |
| EMAIL ADDRESS |  |

|  |  |
| --- | --- |
| **EMERGENCY CONTACT NO 2**(Please indicate if we can share medical information with this person in an **emergency**) | Name:Can we share medical details in an emergency YES/NO |
| RELATIONSHIP (to pilgrim) |  |
| ADDRESS |  |
| EMERGENCY CONTACT NUMBER |  |
| EMAIL ADDRESS |  |

|  |  |
| --- | --- |
| **GENERAL PRACTITIONER’S NAME** |  |
| ADDRESS OF PRACTICE |  |
| TELEPHONE NUMBER |  |
| EMAIL ADDRESS |  |

|  |  |
| --- | --- |
| Have you been to Lourdes as a sick pilgrim before? | YES / NO |
| If yes, which year did you last travel? |  |

**COVID VACCINATION STATUS**

I confirm that I am fully vaccinated against Covid-19 YES/NO

Date of first vaccination…………………………………………………………………………………………………………………………………………………

Date of second vaccination……………………………………………………………………………………………………………………………………………

Date of Booster vaccination 1…………………………………..……2………………………..……………………3…………..……………………………..

I had a positive Covid-19 test on (date)…………………………………………………………………………………………………………………………

I am currently being treated for Long Covid Yes/No (please delete one)

**MEDICAL CONDITIONS**

|  |  |
| --- | --- |
| Please provide a list of your medical conditions/problems including current / ongoing and past problems and details, including dates, of any surgery or admissions to hospital.  | **OFFICIAL USE ONLY**Initial □ |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Do you have any problems with your eyesight, hearing or speech? If so, please state what these are and if you have any aids for these problems. | **OFFICAL USE ONLY**Initial □ |
|  |
|  |  |
|  |
|  |
|  |  |
| Is English your first language? YES / NO |  |
| What language/s, other than English, do you speak? |  |
|  |  |
|  |  |
| Do you use a communication aid? YES / NOIf yes, please list here: |  |
|  |  |
|  |  |
| Do you have any problems with your skin, e.g. pressure sores/ulcers? If yes, please give details of where the problem is, what treatment you use for it and how often you change dressings, etc. (if applicable). |  |
|  |  |
|  |  |
|  |  |
| Do you have any family history of medical problems? |  |
|  |
|  |
|  |
|  |
| Do you have any Psychiatric illnesses or psychological conditions not previously mentioned? Please give details. |  |
|  |  |
|  |
|  |
|  |
|  |  |
|  |  |
| Do you suffer from fits/seizures? Please state how frequent your seizures are (including when the last one was) and what a typical seizure is like for you e.g. vacant episode, lasts a few minutes.  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Do you have any surgery or planned hospital admissions/ investigations scheduled before the Lourdes Pilgrimage? If so, please give details. | **OFFICAL USE ONLY**Initial □ |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Do you have a current ‘do not resuscitate’ (DNACPR) order? |  |
|  |  |
|  |  |
|  |  |
|  |  |

**MEDICATIONS**

Please provide a detailed list of all the medications you take. Please include details of any liquid medicines, injections, inhalers, creams, etc. including ones you may only use infrequently. Please also give details of any Depot injections you receive. Please feel free to attach the MOST RECENT green prescriptions sheet from your GP.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of medicine | Dose | Route (e.g. oral) | Frequency of use(e.g. one in the morning) | **OFFICIAL USE ONLY** |
|  |  |  |  | Initial □ |

|  |  |
| --- | --- |
| Do you require oxygen? If so please state at what flow rate and how often it is required. | **OFFICIAL USE ONLY**Initial □ |
|  |
|  |  |
|  |  |
|  |  |
| Do you have **ALLERGIES/INTOLERANCES? Please give details** |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Can you manage your medications independently?  |  |
| YES/NO (if No please state what assistance you require) |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Do you normally have your medications distributed in a dosette box/blister pack? YES / NO |  |
|  |  |
| Do you smoke? YES / NO |  |
| Do you drink alcohol? YES / NO |  |
| If yes, how many units per week? |  |
|  |  |
|  |  |

**MOBILITY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Capabilities****(Please tick which best applies)** | **Independent** | **Require assistance with 1 person** | **Require assistance with 2 people** | **Fully Dependent** | **Please identify any specific needs** **i.e. what assistance is required** |
| Movement in bed |  |  |  |  |  |
| Getting in and out of bed |  |  |  |  |  |
| Sit to stand |  |  |  |  |  |
| Chair to chair |  |  |  |  |  |
| Walking |  |  |  |  | Is there anything that limits your walking?e.g. Shortness of breath, painIf you are unable to walk - Can you weight bear at all? Y / NDo you feel you can walk down the length of a plane? |
| Toileting |  |  |  |  |  |
| Bathing |  |  |  |  |  |
| Getting up after fall |  |  |  |  |  |
| **BELOW SECTION FOR OFFICE USE ONLY PLEASE MOVE TO NEXT PAGE** |
|  Red Do NOT handle manually (PLEASE CIRCLE) Yellow Caution : This pilgrim has special needs and must be handled in a defined manner Green Go : When employing good load management Principles a pilgrim who can be handled without  risk as long as you consider the principles of safe load management. |
| **PLEASE CONTINUE ON NEXT PAGE** |
| Do you have any problems with arms / upper body / legs? If yes, please give details. |
| Do you have any problems with your muscles or joints? If yes, please give details. |
| Do you have a history of falls? YES /NO |
| Mobility Aids YES / NO(Please include details of the appliances you need.) |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **OFFICE USE ONLY** | Stick | Tripod | Crutches | Zimmer | Handling Belt / Sliding Board or Sheet / Monkey pole  |
|  | Shower chair | Ambulift | Hoist |  |  |
|  | Wheelchair | Do you use a wheelchair? If so, please state how much used (e.g. infrequently / daily / long-distances only / all the time)? | Are you taking your own wheelchair to Lourdes YES / NO |
|  |  |  |  |  | Wheelchair needed at airport YES / NO |
|  |  |  |  |  | Wheelchair needed in Lourdes YES / NO |

**DIET**

|  |  |
| --- | --- |
| Do you require a special diet? (Please Circle) | **OFFICIAL USE ONLY**Initial □ |
| Vegetarian Fat freeVegan Low fibreDiabetic SoftPuree Gluten freeThickened liquids Low saltOther (please specify)  |
|  |
|  |
|  |
|  |
|  |
| Do you have any food allergies? Please state what they are and what happens if you eat these foods. |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Do you have difficulties swallowing? YES / NO |  |
| Do you require any assistance at all with eating/ drinking? - Please be specific e.g. food needs to be cut up and fed to me. |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Do you have any eating or drinking aids e.g. special cup? |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**SLEEP**

|  |  |
| --- | --- |
| Do you have any problems sleeping? Please give details | **OFFICIAL USE ONLY**Initial □ |
|  |
|  |
|  |
|  |  |
|  |  |
| Do you have any medication to help you sleep?YES / NO*If yes, please ensure that you have stated this in the MEDICATION section of this form.* |  |
| Do you sleep in a normal bed at home? YES / NOIf you answered NO, please give details of the special bed/mattress you require |  |

**DAILY LIVING**

|  |  |
| --- | --- |
| What kind of accommodation do you live in? (e.g. nursing home, care home, own home, sheltered accommodation) | **OFFICIAL USE ONLY** |
| Who lives with you? |  |
| Do you have frequent carer/nurse visits/interventions? If so, please give details of what they do for you. |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Do you need help with: (please circle and give details of any help if required) | **PLEASE CIRCLE** |
| * **Washing?**

Fully Independent/Need some assistance/Need full assistance | **Independent/Needs assistance** |
|  |  |
|  - **Dressing?**Fully Independent/Need some assistance/Need full assistance | **Independent/Needs assistance** |
|  |  |
|  - **Going to the toilet?**Fully Independent/Need some assistance/Need full assistance | **Independent/Needs assistance** |
|  |  |
|  |  |
| Do you suffer from incontinence?YES / NO | **OFFICIAL USE ONLY**Initial □ |
|  |  |
| If yes, the please state if this is bowel, bladder or both. |
|  |
|  |
| If yes, do you use pads? \*(Please give details of product type/make) |  |
|  |  |
| Do you have any other problems with your bowels/bladder e.g. constipation? |  |
|  |  |
|  |
| Do you have a catheter? YES \* / NO |  |
| If yes, what type and how often is it changed? Please state if it is intermittent/permanent. |  |
|  |  |
|  |  |
| Do you use a bottle / bedpan / commode / convene\* or other item? Please specify. (Please give details of product type/make)  |  |
|  |  |
| **\*If you use any pads/convenes/catheters please bring enough products with you for the week on Pilgrimage** |  |
| A proportion of your care may be provided by young people. Is there any reason this would concern you? |  |
|  |  |
|  |  |
|  |  |
| *All the information in this form is held in strict confidence and is only used by members of the team of doctors, nurses and carers who will be caring for you during your pilgrimage.* |  |
| Finally, is there anything important you feel you would like us to know about yourself or your care that you have not already mentioned on this form? |  |
|  |  |
|  |  |
|  |  |
| *It is very important that you tell us if there are any significant changes to your general medical state prior to your departure on the pilgrimage. If you have any concerns please contact the pilgrimage office using the details on this form.* |  |

**EXPECTED STANDARDS OF BEHAVIOUR FOR ACCUEIL PILGRIMS**

**“The Co-ordinating Team of the Salford Diocesan Pilgrimage is responsible for ensuring the safety and welfare of all pilgrims in our care, especially those who want to participate as an Accueil pilgrim.  However, the pilgrimage is a voluntary association and while we take all reasonable steps to ensure the full participation and enjoyment of the pilgrimage for Accueil pilgrims, it is essential they understand that there are limitations to the services that can be offered and they co-operate with the arrangements that are in place for the good of all pilgrims, including our volunteer doctors, nurses and carers.**

**The pilgrimage Co-ordinating Team also expect Accueil pilgrims to have a proper regard for their own health, safety and welfare.  As this is a pilgrimage experience, Accueil pilgrims should be mindful that if they wish to consume alcohol, this is done responsibly.**

**For example, Accueil pilgrims must understand that there may be times, particularly in the late evening, when our volunteer numbers are reduced.  Therefore, it may not be possible to provide support and assistance to you if you wish to socialise late into the evening as this places an additional demand on our volunteers and an impact on other pilgrims and their safety.**

**Finally, the Co-ordinating Team emphasise that our volunteers treat people with respect and dignity at all times.  Therefore, it is expected also that those participating as part of the Accueil group also have regard to this and behave appropriately with sensitivity and respect.  Rude or abusive behaviour will not be tolerated.”**

**Declaration**

*(If completed by the applicant).* ***Please see overleaf if you are signing on behalf of the applicant.***

I give my consent for the information contained in this form to be processed and stored for the purposes of my pilgrimage to Lourdes, in accordance with the Data Protection Act 2018. I understand that the information contained on this form will be shared by members of the pilgrimage team responsible for my care and may be shared with other medical professionals in Lourdes should I require additional treatment in hospital or other care facility.

The pilgrimage doctor may contact my General Practitioner, to confirm my medical details.

I understand that attending the pilgrimage is subject to my attendance at a Medical Assessment Day at the Cathedral Centre.

I understand that it is imperative that if the information I have given above should change prior to the pilgrimage, then it is my responsibility to inform the Medical and Nursing Team. I declare that the information I have given on this form is correct and true to my knowledge.

Name: Date:

Signed:

*If completed by a carer or family member who is appropriate authorised:*

I give my consent for the information contained in this form to be processed and stored for the purposes of the applicant’s pilgrimage to Lourdes in accordance with the Data Protection Act 2018. I understand that the information contained on this form will be shared by members of the pilgrimage team responsible for my care and may be shared with other medical professionals in Lourdes should I require additional treatment in hospital or other care facility.

The pilgrimage doctor may contact the pilgrim’s General Practitioner, to confirm medical details.

I understand that attending the pilgrimage is subject to the pilgrim attending a Medical Assessment Day at the Cathedral Centre.

I understand that it is imperative that if the information given above should change prior to the pilgrimage, then it will be my responsibility to inform the Medical and Nursing Team. I declare that the information I have given on this form is correct and true to my knowledge and that I am suitably authorised to provide this information.

Name: Date:

Signed:

Relationship:

**FOR OFFICIAL USE ONLY**

**Checklist for pilgrims on assessment day**

|  |  |  |  |
| --- | --- | --- | --- |
|   | **YES** | **NO** | **COMMENTS** |
| **Form A received and reviewed**  |   |   |   |
| **Form B received and reviewed** |   |   |   |
| **Nursing assessment completed** |   |   |   |
| **Covid risk assessment completed** |   |   |   |
| **COVID VACCINATION VERIFIED** |   |   |   |
| **Doctor’s check completed** |   |   |   |
| **Medicine chart completed by DOCTOR (if applicable)** |   |   |   |

1. **Pilgrim provided with information booklet? YES / NO**
2. **Accommodation discussed? YES / NO (Does the pilgrim have any specific concerns or anxieties?)**
3. **Self Medicating YES / NO**
4. **Rise and fall bed needed? YES / NO**
5. **Is a hoist required? YES / NO**

**Please Circle Which Applies**

|  |  |  |  |
| --- | --- | --- | --- |
| **Airport** | **On/Off Plane** | **Lourdes- Accueil** | **Lourdes-** **out and about** |
| Walk Walk with help Own chairAirport chair | Walk Walk with help Stand& transferChair | Walk Walk with help Own ChairAccueil Chair   |  Voiture Chair Stretcher |

**Nurse Assessor Signature**

**Nurse Assessor Name**

**Date**

**Reviewed by:…………………………………………….Date…………………………………………**

**SECTION B**

(Please present this letter and the accompanying form to your GP and then return to the Pilgrimage office once completed.)

Salford Diocesan Pilgrimage Office,

Cathedral Centre

3 Ford Street

Salford

M3 6DP

Tel: 0161 817 2209

Email: lourdes.pilgrimage@dioceseofsalford.org.uk

Jan 2024

Dear Doctor,

**SALFORD DIOCESAN PILGRIMAGE TO LOURDES, 2024.**

Your patient has applied to go to Lourdes, a Roman Catholic Shrine in the South West of France, as one of the officially registered Sick Pilgrims on our Diocesan Pilgrimage to Lourdes this August. Going to Lourdes on this pilgrimage is something that many pilgrims benefit greatly from, spiritually, emotionally, socially and sometimes physically and there is evidence to support that it can improve pilgrim quality of life. During the 6 day pilgrimage, supported pilgrims are cared for by a qualified and experienced team of doctors, nurses and volunteers. Each pilgrim has a full assessment prior to travel to ensure we can meet their care needs.

In order to comply with our insurance regulations, it is necessary to ascertain from the pilgrim’s usual medical practitioner that there are no specific reasons to their knowledge that the pilgrim could not travel. If you are unsure about this please contact me on the details below to discuss.

It is also important for us to ascertain key medical information, as this will assist the Pilgrimage Medical team responsible for the care of your patient during the pilgrimage. To reduce the amount of paperwork this creates for your practice **PLEASE ATTACH A GP SUMMARY PRINTOUT** to this form which has all relevant medical problems, medications, allergies etc. This will then be used in conjunction with the information gained from the assessment of the pilgrim prior to travel. This information is, of course, confidential to the medical and nursing staff. If there are any fees applicable to the completion of this certificate, please direct them to the Pilgrimage Office via the address given above.

If you have any queries please do not hesitate to contact me on 07762-630097 or via e-mail to the pilgrimage office.

Thanking you in advance for your co-operation.

Yours sincerely,

**Dr Jennifer Klimiuk**

Medical Director

**SECTION B**

**MEDICAL CERTIFICATE.**

(To be completed by the medical practitioner of the applicant)

|  |  |
| --- | --- |
| PATIENT’S NAME |  |
| ADDRESS |  |
| KNOWN AS |  |
| DATE OF BIRTH |  |

1. **To the best of your knowledge, do you know of any reason why this pilgrim should NOT be able to travel to Lourdes with the Salford Diocesan Pilgrimage?**

**YES/NO**

**(If you are uncertain please contact the pilgrimage medical director on details above to discuss.)**

**……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….**

1. **Is a GP SUMMARY PRINTOUT attached to this form? YES/NO**

 **If not please attach before returning**

|  |  |
| --- | --- |
| The medical and nursing team on this pilgrimage are assisted in some areas by volunteers, some of whom are young people under the age of 18 years. These volunteers help with cleaning tasks, making drinks and pushing wheelchairs. Is there any reason that this may cause concern to you? | **OFFICIAL USE ONLY** |
|  |  |
|  |  |
|  |  |
| Are there likely to be any major changes in any of the above details before the pilgrimage departs? |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Is there any other information about this patient that you feel would be important for us to know? |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Please indicate if we have your permission to contact yourself / your practice should we have any further queries relating to your patient. | **OFFICIAL USE ONLY** |
|  |  |
|  |  |
|  |  |
|  |  |
| Does this patient have a current, valid DNACPR order?YES/NO |  |
|  |  |
|  |  |
|  |  |

**Thank you for taking the time to complete this medical form. It is very much appreciated and will greatly assist preparations for your patient’s journey and care in Lourdes.**

|  |  |
| --- | --- |
| DOCTOR’S NAME |  |
| SIGNATURE |  |
| DATE |  |
| ADDRESS OF PRACTICE |  |
| TELEPHONE |  |
| EMAIL  |  |