**Archies Caravan **

**Application Form**

**Submitting Completed Forms**

* This form must be completed by a **Healthcare or Social Care professional**. Patients and relatives **cannot** complete this form.
* Has consent been obtained from the patient/relative for the application to be made and the sharing of their data with Archies Caravan. **Yes:**
* Please refer to the guidance notes within the application form information

regarding completion of the form.

* The personal information and medical details on this form will only be used by Archies Caravan for the use of processing this application. We will not disclose this information to other organisation.

#### Post completed forms to:

Archies Caravan

14 Earlsmere Drive

Morley

Leeds

LS279RY

**Or email them to:** archiescaravan@yahoo.com

### Patient Details

Title: \_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_ :

DOB: \_\_ / \_\_ / \_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current/ Previous Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_

### Parent/Carer details (if applicable)

Title: \_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB: \_\_ / \_\_ / \_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different to above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Declaration:** I confirm that the information provided is correct the best of my knowledge

### Applicant details (health or social care professional)

Title: \_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_ Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Declaration:** I confirm that the information provided is correct the best of my knowledge

**Note:** We cannot process an application if this section is not completed.

Medical Details

1. Does the above named person have a cancer diagnosis? Please circle: YES / NO
2. Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Date of Diagnosis: \_\_\_ / \_\_\_ / \_\_\_ Is the patient aware? Please circle: YES / NO
4. Current or previous treatment (Surgery, Radiotherapy, Chemotherapy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Hospital Consultant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Hospital where patient is receiving treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. GP. Including the address and contact:

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please confirm written confirmation from a medical professional claiming the patient’s cancer diagnosis within the 12 month period preceding the date of the application.

# Guidance notes - completing the form

## Section 1 - Patient details

Consent for the use of personal data and for the application of the grant must be obtained from the patient. If a patient is unable to give consent, ie they are a minor, then a parent or someone with power of attorney for the patient should give consent.

## Section 2 - Applicant details

Archies Caravan does not accept referrals directly from patients or relatives.

Applications must be completed and signed by a healthcare or social care professional such as a Clinical nurse specialist, Social worker, a therapist, hospital doctor, a community nurse or a GP.

## Section 3 - Medical report

The medical report enables Archies Caravan to award places as per medical criteria. The medical information will only be used by the grant application panel.