

TRAVEL RISK ASSESSMENT FORM

Please complete this form and return to reception. Your appointment will only be booked once the form is completed .

It is the responsibility of the patient to allow ample time for completion of vaccine courses, in some cases this may take up to 6 weeks.

| Personal details | | | |
|--|---------------------------|-----------------------|------------------|
| Name: | Date of birth: | | |
| Address: | NHS Number : | | |
| | Contact telephone number: | | |
| | Mobile: | | |
| Landline: | | | |
| E mail: | | | |
| Please supply information about your trip in the sections below | | | |
| Date of Departure: | | Total length of trip: | |
| Country to be visited | Exact location or region | City or Rural | Length of Stay |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| Type of travel and purpose of trip – please tick all that apply | | | |
| <input type="checkbox"/> Holiday <input type="checkbox"/> Staying in hotel <input type="checkbox"/> Backpacking | | | Additional Info: |
| <input type="checkbox"/> Business Trip <input type="checkbox"/> Cruise ship trip <input type="checkbox"/> Camping/hostels | | | |
| <input type="checkbox"/> Expatriate <input type="checkbox"/> Safari <input type="checkbox"/> Adventure | | | |
| <input type="checkbox"/> Volunteer Work <input type="checkbox"/> Pilgrimage <input type="checkbox"/> Diving | | | |
| <input type="checkbox"/> Healthcare Worker <input type="checkbox"/> Medical tourism <input type="checkbox"/> Visiting friends/family | | | |
| Please supply details of your personal medical history | | | |
| | YES | NO | DETAILS |
| Are you fit and well today | | | |
| Any allergies including food, latex, medication | | | |
| Severe reaction to a vaccine before | | | |
| Tendency to faint with injections | | | |
| Any surgical operations in the past, including having spleen or thymus gland removed | | | |
| Recent chemotherapy/radiotherapy/organ transplant | | | |
| Anaemia | | | |

TRAVEL RISK ASSESSMENT FORM

| | YES | NO | DETAILS |
|--|-----|----|---------|
| Bleeding/clotting disorders (history of DVT) | | | |
| Heart disease (eg. angina, high blood pressure) | | | |
| Diabetes | | | |
| Disability | | | |
| Epilepsy/seizures | | | |
| Gastrointestinal (stomach) complaints | | | |
| Liver and or kidney problems | | | |
| HIV/AIDS | | | |
| Immune system condition | | | |
| Mental health issues (including anxiety, depression) | | | |
| Neurological (nervous system) illness | | | |
| Respiratory (lung) disease | | | |
| Rheumatology (joint) conditions | | | |
| Spleen problems | | | |
| Any other conditions? | | | |
| Women only: | | | |
| Are you pregnant? | | | |
| Are you breast feeding? | | | |
| Are you planning pregnancy while away? | | | |

Are you currently taking any medication (including prescribed, purchased or a contraceptive pill?)

Please supply information on any past vaccines or malaria tablets

| Have you had this vaccination before? | | | Have you had this vaccination before? | | |
|---------------------------------------|----------|-------|---------------------------------------|---------|-------|
| Tetanus/Polio/Diphtheria | Yes / No | Date: | Influenza | Yes/ No | Date: |
| Typhoid | Yes / No | Date: | Pneumococcal | Yes/ No | Date: |
| Cholera | Yes / No | Date: | Meningitis | Yes/ No | Date: |
| Rabies | Yes / No | Date: | TickBorne Encephalitis | Yes/ No | Date: |
| Yellow fever | Yes / No | Date: | Malaria tablets | Yes/ No | Date: |
| Japanese Encephalitis | Yes / No | Date: | | | |
| MMR | Yes / No | Date: | | | |
| Hepatitis A | Yes / No | Date: | | | |
| Hepatitis B | | | | | |
| BCG | | | | | |

TRAVEL RISK ASSESSMENT FORM

Any additional information:

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed _____ Date _____

TRAVEL RISK ASSESSMENT FORM

Travel risk assessment performed Yes [] No []

TRAVEL VACCINES RECOMMENDED FOR THIS TRIP

| Disease protection | Yes | No | Further information |
|-------------------------|-----|----|---------------------|
| Hepatitis A | | | |
| Hepatitis B | | | |
| Hepatitis A & B | | | |
| Hepatitis A & Typhoid | | | |
| Typhoid | | | |
| Cholera | | | |
| Tetanus | | | |
| Diphtheria | | | |
| Polio | | | |
| Meningitis ACWY | | | |
| Yellow Fever | | | |
| Rabies | | | |
| Japanese B Encephalitis | | | |
| Other | | | |

TRAVEL ADVICE AND LEAFLETS GIVEN AS PER TRAVEL PROTOCOL

| | | | | | |
|--|--|-----------------------|--|-------------------------|--|
| Food water and personal hygiene advice | | Travellers' diarrhoea | | Hepatitis B and HIV | |
| Insect bite prevention | | Animal bites | | Accidents | |
| Insurance | | Air travel | | Sun and heat protection | |
| Websites | | Other | | | |

MALARIA PREVENTION ADVICE and MALARIA CHEMOPROPHYLAXIS

| | | | |
|---------------------------|--|-----------------------------------|--|
| Chloroquine and proguanil | | Atovaquone + proguanil (Malarone) | |
| Chloroquine | | Mefloquine | |
| Doxycycline | | Malaria advice leaflet given | |

| FURTHER INFORMATION |
|----------------------|
| e.g. weight of child |

Signed by:

Date:.....

Position: