

BILLESDON SURGERY

TRAVEL RISK ASSESSMENT FORM

Please complete this form prior to your travel appointment and return it to reception.
You will then need to telephone reception after 5 working days to be informed if anything is required.

| Personal details | | | | | | |
|---|----------------|---|---|--------------------------|-------------|--------------------------|
| Name: | | | Date of birth: | | | |
| | | | Male <input type="checkbox"/> Female <input type="checkbox"/> | | | |
| Easiest contact telephone number | | | | | | |
| E mail | | | | | | |
| Dates of trip | | | | | | |
| Date of Departure | | | | | | |
| Return date or overall length of trip | | | | | | |
| Itinerary and purpose of visit | | | | | | |
| Country (and towns/cities) to be visited | Length of stay | Away from medical help at destination, if so, how remote? | | | | |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| Please tick as appropriate below to best describe your trip | | | | | | |
| 1. Type of trip | Business | <input type="checkbox"/> | Pleasure | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| 2. Holiday type | Package | <input type="checkbox"/> | Self organised | <input type="checkbox"/> | Backpacking | <input type="checkbox"/> |
| | Camping | <input type="checkbox"/> | Cruise ship | <input type="checkbox"/> | Trekking | <input type="checkbox"/> |
| 3. Accommodation | Hotel | <input type="checkbox"/> | Relatives / family home | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| 4. Travelling | Alone | <input type="checkbox"/> | With family / friend | <input type="checkbox"/> | In a group | <input type="checkbox"/> |
| 5. Staying in area which is | Urban | <input type="checkbox"/> | Rural | <input type="checkbox"/> | Altitude | <input type="checkbox"/> |

| | | | | | | | |
|--|--------|--|-----------|--|-------|--|--|
| 6. Planned activities | Safari | | Adventure | | Other | | |
| Personal medical history | | | | | | | |
| Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions, thymus disorder) | | | | | | | |
| List any current or repeat medications | | | | | | | |
| Do you have any allergies for example to eggs, antibiotics, nuts ? | | | | | | | |
| Have you ever had a serious reaction to a vaccine given to you before? | | | | | | | |
| Does having an injection make you feel feint? | | | | | | | |
| Do you or any close family members have epilepsy? | | | | | | | |
| Do you have any history or mental illness including depression or anxiety | | | | | | | |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | | | | | | | |
| <i>Women only:</i> Are you pregnant or planning pregnancy or breast feeding? | | | | | | | |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company about his? | | | | | | | |
| Please write below any further information which may be relevant | | | | | | | |

| | | | | | |
|---|--|--------------|--|-------------|--|
| Vaccination History | | | | | |
| Have you ever had any of the following vaccinations / malaria tablets and if so when? | | | | | |
| Tetanus | | Polio | | Diphtheria | |
| Typhoid | | Hepatitis A | | Hepatitis B | |
| Meningitis | | Yellow Fever | | Influenza | |
| Rabies | | Jap B Enceph | | Tick Borne | |
| Other | | | | | |
| Malaria tablets | | | | | |

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 _____

| For official use | | | |
|--|------------|-----------------------------------|----------------------------|
| Patient Name: | | | |
| Travel risk assessment performed Yes [] No [] | | | |
| TRAVEL VACCINES RECOMMENDED FOR THIS TRIP | | | |
| Disease protection | Yes | No | Further information |
| Hepatitis A | | | |
| Hepatitis B | | | |
| 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 | | Travel Record card supplied | |
| | | OTHER | |
| MALARIA PREVENTION ADVICE and MALARIA CHEMOPROPHYLAXIS | | | |
| Chloroquine and proguanil | | Atovaquone + proguanil (Malarone) | |
| Chloroquine | | Mefloquine | |
| Doxycycline | | Malaria advice leaflet given | |

FUTHER INFORMATION

e.g. weight of child

Signed by:

Position:

Date:

Now scan this form into the patient's record on the computer for evidence of best practice