

BILLESDON SURGERY

TRAVEL RISK ASSESSMENT FORM

Please complete this form prior to your travel appointment and return to reception with your **£25 refundable deposit**.

You will then need to telephone reception after 3 working days to be informed if anything is required.

Personal details						
Name:	Date of birth:					
	Male [] Female []					
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		Pleasure		Other	
2. Holiday type	Package		Self organised		Backpacking	
	Camping		Cruise ship		Trekking	
3. Accommodation	Hotel		Relatives / family home		Other	
4. Travelling	Alone		With family / friend		In a group	
5. Staying in area	Urban		Rural		Altitude	

which is						
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