[](http://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwjEu_f48KTOAhUJIsAKHX18A9EQjRwIBw&url=http://holykaw.alltop.com/from-the-uh-oh-files-mosquitoes-ignore-deet&psig=AFQjCNFLz_gg1Vc9T5LHuounmi0rVj6JjQ&ust=1470300310171738)

**PLEASE COMPLETE THE TRAVEL ASSESSMENT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | | | | | | |
| **Name:** | | | | | **Date of Birth**  **Male / Female** | | | | |
| **Contact Number:** | | | | | | | | | |
| **Email:** | | | | | | | | | |
| **Dates of Trip** | | | | | | | | | |
| **Date of Departure** | | | | | | | | | |
| **Return date or overall length of trip** | | | | | | | | | |
| **Itinerary and purpose of visit** | | | | | | | | | |
| **Country to be visited** | | **Length of stay** | | | | **Away from medical help at destination if so, how remote?** | | | |
| **1.** | |  | | | |  | | | |
| **2.** | |  | | | |  | | | |
| **Future Travel Plans** | |  | | | |  | | | |
|  | |  | | | |  | | | |
| **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 which is** | **Urban** | |  | **Rural** | | |  | **Altitude** |  |
| **6. Planned Activities** | **Safari** | |  | **Adventure** | | |  | **Other** |  |
| **Personal Medical History** | | | | | | | | | |
| **Do you have any recent or past medical history of note? (including diabetes, heart of lung conditions)** | | | | | | | | | |
| **List any current or repeat medications** | | | | | | | | | |
| **Do you have any allergies for example to eggs, antibiotics, nuts?**  **YES / NO** | | | | | | | | | |
| **Have you ever had a serious reaction to a vaccine given to you before?**  **YES / NO** | | | | | | | | | |
| **Does having an injection make you feel faint?**  **YES / NO** | | | | | | | | | |
| **Do you or any close family members have epilepsy?**  **YES / NO** | | | | | | | | | |
| **Do you have any history or mental illness including depression or anxiety?**  **YES / NO** | | | | | | | | | |
| **Have you recently undergone radiotherapy, chemotherapy or steroid treatment?**  **YES / NO** | | | | | | | | | |
| **Women only: are you pregnant or planning pregnancy or breast feeding?**  **YES / NO** | | | | | | | | | |
| **Have you taken out travel insurance and if you have a medical condition, informed the insurance e company about this? YES / NO** | | | | | | | | | |
| **Please write below any further information which may be relevant.** | | | | | | | | | |

**P.T.O**

**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 risk 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** | | |  |
| **website** | | **Travel record supplied YES / NO** | | | | | | | |
| **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:………………………………………………………………………. Date:……………………………………………………………….**