

**PLEASE COMPLETE THE TRAVEL ASSESSMENT**

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| **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:………………………………………………….**

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| **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:……………………………………………………………….**