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| **Lofthouse and The Manse Surgery Surgery****Travel Risk Assessment Form****Date form given to patient****…………………………………..** |

Please complete this form and hand it in at reception as soon as possible.

**If your date of travel is within the next 6 weeks, we WILL NOT have the capacity to provide travel advice and immunisations – please see overleaf for details of alternative travel clinics.**

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| **Personal Details** |
| Name: | Date of Birth |
| Daytime contact telephone no. |
| **Dates of trip** |
| Date of Departure |  |
| Return date or overall length of trip |  |
| **Itinerary & purpose of visit** |
| Country Visiting & Specific Area | Length of Stay | Away from medical help at destination. If so, how remote? |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| **Please tick as appropriate below to best describe your trip.** |
| 1. Type of Trip
 | Business |  | Pleasure |  | Other |  |
| 1. Holiday Type
 | Package |  | Self-organised |  | Backpacking |  |
| Camping |  | Cruise ship |  | Trekking |  |
| 1. Accommodation
 | Hotel |  | Relatives/family home |  | Other |  |
| 1. Travelling
 | Alone |  | Family/friends |  | Group |  |
| 1. Type of area staying in
 | Urban |  | Rural |  | Altitude |  |
| 1. Planned activities
 | Safari |  | Adventure |  | Other |  |

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| **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 Encephalitis |  | Tick Borne |  |
| Pneumonia |  | Other |  |  |  |
| Malaria Tablets: |

**Personal Medical History**

|  |
| --- |
| Do you have any recent or past medical history of note? Including diabetes, Heart or lung conditions: |
| List any current or repeat medications |
| Do you have any allergies? |
| Have you ever had a serious reaction to a vaccine in the past? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatments? |
| **\*Women Only:** Are you pregnant or planning to become pregnant or breastfeeding? |
| Have you taken out adequate Travel Insurance and if you have any medical condition, informed the insurance company about this? |

\*For discussion when risk assessment is performed and during any travel consultation:

I have no reason to think that I might be pregnant and am aware that I cannot try to conceive within 6 months on my return to the UK.

I will receive information on the risks of the vaccines recommended and will have had the opportunity to ask questions at any consultation required hereafter. I consent to vaccines being given.

**Signed : ………………………………… Date: ……………………..**

**Travel Clinics**

* Masta Travel Clinic : 0113 2387500
* Superdrug Clinic : 03333 111 007
* Woodhouse Medical Practice : 0113 2213533
* Boots Travel Health & Vaccination Clinics : Book on-line via [www.boots.com](http://www.boots.com)

Please check on the website [www.fitfortravel.nhs.uk](http://www.fitfortravel.nhs.uk) for further travel advice or visit the Nathnac website at [www.nathnac.net](http://www.nathnac.net) . The surgery is not allowed to offer all vaccinations i.e. rabies; yellow fever; Japanese Encephalitis; cholera; meningitis, Tick Borne Encephalitis and Hepatitis B.

**PLEASE NOTE: NOT ALL TRAVEL VACCINATIONS ARE FREE ON THE NHS**.

Please return to the practice, a completed form for each family member who will be travelling.

To find out what travel vaccinations, if any are required, please ring the practice 4 weeks after the completed travel forms have been returned.

Thank you.

**For Surgery Use Only:**

**Travel risk assessment:**

**Travel Vaccinations recommended for this trip:**

|  |
| --- |
| Hepatitis A Yes ( ) No ( ) |
| Hepatitis B Yes ( ) No ( ) |
| Typhoid Yes ( ) No ( ) |
| Cholera Yes ( ) No ( ) |
| Tetanus/Diptheria/Polio Yes ( ) No ( ) |
| Meningitis ACWY Yes ( ) No ( ) |
| Yellow Fever Yes ( ) No ( ) |
| Rabies Yes ( ) No ( ) |
| Jap B Encephalitis Yes ( ) No ( ) |
| Other Yes ( ) No ( ) |

**Travel Advice to be given:**

Food/Water and Personal Hygiene Advice ( )

Traveller’s Diarrhoea ( )

Insect Bite Prevention ( )

Animal Bites ( )

Insurance ( )

Sun/Heat Protection ( )

Hep B and HIV ( )

**Malaria Prevention Advice/Malaria Chemoprophylaxis** - Patient to speak to MASTA or Pharmacy.

Date completed by P/N : …………………………………….