**ALMOND ROAD SURGERY**

**Travel assessment form – To Be Completed by Practitioner**

Please take this form to a travel clinic or pharmacy offering a travel assessment service. The form needs to be fully completed and signed by assessor and patient. Return completed form to surgery where prescriptions for required vaccines available on the NHS will be issued.

Prescriptions can be taken to chosen pharmacy. Vaccines collected by patients need to be stored between 2-8 degrees C to maintain their efficacy. Please bring them to the surgery for storing in our vaccine fridges as soon as practical.

When vaccines have been obtained an appointment can be made with a Practice Nurse.

Travel assessment carried out by (Practitioner Name)..................................................................................................

Organisation.(Pharmacy/travel Clinic Name).................................................................................................................

Date of Assesment........................................................................................................................................................

**Traveller Name ........................................................................................................Date of Birth...............................**

**Travel information**

|  |  |
| --- | --- |
| **Country of travel** |  |
| **Area within country** |  |
| **Dates of travel** |  |
| **Accommodation type** |  |
| **Purpose of travel** |  |

**Vaccines recommended and available on the NHS**

|  |  |  |
| --- | --- | --- |
|  | **Vaccine name available to prescribe** | **Required**  |
| **Tetanus/Diphtheria/Polio** |  |  |
| **Hepatitis A** |  |  |
| **Hepatitis A/Hepatitis B** |  |  |
| **Typhoid** |  |  |
| **Cholera** |  |  |

**Other non NHS vaccines discussed. To be given by pharmacist/Travel clinic if required.**

**......................................................................................................................................................................................**

**......................................................................................................................................................................................**

**Bite avoidance advice Yes / No. Malaria advice Yes / No Prophylaxis discussed Yes / No**

**Medication recommended and supplied...................................................................................................................**

**……………………………………………………………………………………………………………………………………**

**I can confirm that the above information is correct**

**Patient signature ................................................................................................................Date................................**