| **TRAVEL RISK ASSESSMENT FORM – Traveller to complete prior to appointment** | |
|---|---|
| **Name:**<br><br>**NHS No:** | Date of Birth:<br><br>Male: Female: |
| **Email:** | Telephone No:<br><br>Mobile No: |

**PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW:**

| **Date of Departure:** | | Total length of trip: | |
|---|---|---|---|
| **COUNTRY TO BE VISITED** | **EXACT LOCATION OR REGION** | **CITY OR RURAL** | **LENGTH OF STAY** |
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |

**Have you taken out travel insurance for this trip?**

**Do you plan to travel abroad again in the future?**

**TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY**

| | | | |
|---|---|---|---|
| ❒ **Holiday** | ❒ **Staying in Hotel** | ❒ **Backpacking** | Additional Information |
| ❒ **Business trip** | ❒ **Cruise ship trip** | ❒ **Camping/Hostels** | |
| ❒ **Expatriate** | ❒ **Safari** | ❒ **Adventure** | |
| ❒ **Volunteer work** | ❒ **Pilgrimage** | ❒ **Diving** | |
| ❒ **Healthcare worker** | ❒ **Medical tourism** | ❒ **Visiting friends/family** | |

**PLEASE SUPPLY DETAIS OF YOUR PERSONAL MEDICAL HISTORY**

| | **YES** | **NO** | **DETAILS** |
|---|---|---|---|
| Are you fit and well today | | | |
| Any allergies including food, latex, medication | | | |
| Severe reaction to a vaccine before | | | |
| Tendency to faint with injections | | | |
| Any surgical operations in the past, including e.g. your spleen or thymus gland removed | | | |
| Recent chemotherapy/radiotherapy/organ transplant | | | |
| Anaemia | | | |
| Bleeding/clotting disorders (incl history of DVT) | | | |
| Heart Disease | | | |
| Diabetes | | | |
| Disability | | | |
| Epilepsy/seizures | | | |
| Gastrointestinal (stomach) complaints | | | |
| Liver and/or Kidney problems | | | |
| HIV/AIDS | | | |
| Immune system condition | | | |
| Mental Health issues (incl anxiety, depression) | | | |

| | YES | NO | DETAILS |
|---|---|---|---|
| Neurological (nervous system) illness | | | |
| Respiratory (lung) disease | | | |
| Rheumatology (joint) conditions | | | |
| Spleen problems | | | |
| Any other conditions? | | | |
| **Women only** | | | |
| Are you pregnant | | | |
| Are you breast feeding | | | |
| Are you planning pregnancy whilst away | | | |
| Have you undergone FGM/been cut/circumcised | | | |

| **Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?** |
|---|
| |

| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** | | | | | |
|---|---|---|---|---|---|
| **Tetanus/polio /Diptheria** | | **MMR** | | **Influenza** | |
| **Typhoid** | | **Hepatitis A** | | **Pneumococcal** | |
| **Cholera** | | **Hepatitis B** | | **Meningitis** | |
| **Rabies** | | **Japanese Encephilitis** | | **Tick Borne Encephilitis** | |
| **Yellow Fever** | | **BCG** | | **Other** | |
| **Malaria Tablets** | | | | | |

## TRAVEL VACCINE FEES

| VACCINE | COST PER INJECTIONS | NUMBER OF COURSES | COST PER COURSE |
|---|---|---|---|
| MMR | FREE | | |
| Cholera | £30.00 | 2 | £60.00 |
| Dip/Tet/Polio | FREE | | |
| Hep A | FREE | | |
| Hep B | £35.00 | 3 | £105.00 |
| Hepatyrix | FREE | | |
| Meningitis ACWY | £45.00 | 1 | £45.00 |
| Rabies | £47.00 | 3 | £141.00 |
| Twinrix | FREE | | |
| Typhoid | FREE | | |
| Yellow Fever (inc cert) | £70.00 | 1 | £70.00 |
| Travel Pack | £26.00 | | |

| 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 | | | |
| MMR x 2 | | | |
| Other | | | |

| TRAVEL ADVICE AND LEAFLETS GIVEN AS PER TRAVEL PROTOCOL | | | | | |
|---|---|---|---|---|---|
| Food, water and personal hygiene advice | | Traveller's diarrhoea | | Hep B and HIV | |
| Insect bite protection | | Animal Bites | | Accidents | |
| Insurance | | Air travel | | Sun and heat protection | |
| Websites | | Travel Record Card Supplied | | | |
| Malaria Risk ❒ YES ❒ NO | | | | | |
| Chloroquine and proguanil | | Atovaquone + proguanil (Malarone | | | |
| Chlorquine | | Mefloquine | | | |
| Doxycycline | | Malaria advice leaflet given | | | |

FURTHER INFORMATION e.g. current outbreaks/child weight, etc

Patient Specific Direction

I authorise the Practice Nurse below to administer the above named vaccine/s to the patient listed below:

Signed by GP:_____ Date:_____

Signed by Practice Nurse: _____ Date: _____

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.

Patient's Name/Signature:_____ Date:_____

(Form to be scanned onto patient's record on computer)