

NORTH STREET MEDICAL CARE

TRAVEL RISK ASSESSMENT FORM

Ideally to be completed by traveler 6 WEEKS prior to travel



| | | | | |
|---|---------------------------------|---|--|-------------------------------|
| Name: | | Date of birth | | |
| | | Male <input type="checkbox"/> Female <input type="checkbox"/> | | |
| E mail: | | Telephone number: | | |
| | | Mobile number: | | |
| 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 | | | | |
| <input type="checkbox"/> Holiday | | <input type="checkbox"/> Staying in hotel | <input type="checkbox"/> Backpacking | <u>Additional information</u> |
| <input type="checkbox"/> Business trip | | <input type="checkbox"/> Cruise ship trip | <input type="checkbox"/> Camping/hostels | |
| <input type="checkbox"/> Expatriate | | <input type="checkbox"/> Safari | <input type="checkbox"/> Adventure | |
| <input type="checkbox"/> Volunteer work | | <input type="checkbox"/> Pilgrimage | <input type="checkbox"/> Diving | |
| <input type="checkbox"/> Healthcare worker | | <input type="checkbox"/> Medical tourism | <input type="checkbox"/> Visiting friends/family | |
| PLEASE SUPPLY DETAILS 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 (including history of DVT) | | | | |
| Heart disease (e.g. angina, high blood pressure) | | | | |
| Diabetes | | | | |
| Disability | | | | |
| Epilepsy/seizures | | | | |
| Gastrointestinal (stomach) complaints | | | | |
| Liver and or kidney problems | | | | |
| HIV/AIDS | | | | |
| Immune system condition | | | | |

| | YES | NO | DETAILS |
|--|-----|----|---------|
| Mental health issues (including anxiety, depression) | | | |
| 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 while away? | | | |
| Have you undergone FGM / been cut / circumcised | | | |

| Are you currently taking any medication? (including prescribed, purchased or a contraceptive pill) |
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| PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST | | | | | |
|---|--|-----------------------|--|-------------------------|--|
| Tetanus/polio/diphtheria | | MMR | | Influenza | |
| Typhoid | | Hepatitis A | | Pneumococcal | |
| Cholera | | Hepatitis B | | Meningitis | |
| Rabies | | Japanese Encephalitis | | Tick Borne Encephalitis | |
| Yellow fever | | BCG | | Other | |
| Malaria Tablets | | | | | |

| Any additional information |
|-----------------------------------|
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| GP Authorisation to provide private vaccines i.e. YF, Rabies and Japanese encephalitis |
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Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine*. RCN, London. www.rcn.org.uk
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.