Travel Risk Assessment Form

To be completed prior to appointment

PLEASE RETURN TO DOWER HOUSE SURGERY RECEPTION

NEWPORT HEALTH CENTRE

Patient Details			
Name		Date of birth	
Address		NHS number	
		Home Telephone	
Email		Mobile Telephone	

Travel Itinerary					
	Dates	**Country**	**Exact location/region**	**City or Rural**	**Length of Stay**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Please continue on new page if required…...

Travel Information (please tick all that apply)				
Type	□ Holiday	□ Business trip	□ Volunteer work	□ Visiting friends/family
	□ Expatriate	□ Cruise ship	□ Healthcare worker	□ Pilgrimage
Accommodation	□ Hotel	□ Camping	□ Hostels	□ Friends/Family
Activities	□ Safari	□ Diving	□ Adventure	
Additional information:				

Medical History			
	Yes	**No**	**Details**
Are you fit and well today			
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			

	Yes	No	Details
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			
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?			

Information on any vaccines or malaria tablets taken in the past					
Tetanus/Polio/Diptheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Japanese Encephalitis		Rabies		Yellow Fever	
Tick Borne Encephalitis		BCG		Other	
Malaria Tablets					

Allergies

Please amend this as necessary (include food, latex and medication)

Medications

Please amend this as necessary (include prescribed, purchased or contraceptive pill)

Acute Medication

Repeat Medication

Further Information

Have you taken out travel insurance for this trip?

Do you plan to travel abroad again in the future?

Other information:

TO BE COMPLETED BY PRACTICE NURSE **Vaccines the patient requires -**					
Tetanus/Polio/Diptheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Japanese Encephalitis		Rabies		Yellow Fever	
Tick Borne Encephalitis		BCG		Other	
Malaria Tablets					

Nurse Name: _____

Nurse Signature: _____

Appointment made?: _____