 

Travel Risk Assessment Form

**Health professionals**: local guidance for record keeping should be followed.

|  |  |
| --- | --- |
| Name: | Date of Birth: |
| Address: | Telephone: |
|  | Email: |

# Travel details

|  |  |
| --- | --- |
| Departure date: | Total length of trip: |
| Return date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| COUNTRY | DESTINATION(S) WITHIN THE COUNTRY | LENGTH OF STAY | MODE OF TRANSPORT |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

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|  |  |  |  |
| --- | --- | --- | --- |
| Urban (town / city) | Rural (countryside) | Jungle | Desert |
| Coastal | High altitude |  | Safari |
| Other (please provide details): |  |  |

# Purpose of trip – circle all that apply

|  |  |  |  |
| --- | --- | --- | --- |
| Adventure / Gap year Backpacker | Aid work / Emergency response | Business / Work | Charity / Volunteer |
| Cruise | Diving | Health worker | Holiday |
| Long term / Expatriate | Medical treatment | Pilgrimage | Visiting friends and family |
| Other (please provide details): |  |  |

**Accommodation – circle all that apply**

|  |  |  |  |
| --- | --- | --- | --- |
| Hotel | Hostel | Camping | Staying with family / friends |
| Other (please provide details): |  |  |

|  |  |  |
| --- | --- | --- |
| **Do you have travel health insurance (covering pre-existing health conditions and planned activities if relevant)?** | Yes | No |

Please tick either yes or no. If you answer yes to any of the questions, please provide details below.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Are you well today? |  |  |
| Do you have any health conditions? E.g. diabetes, respiratory (breathing) problems, heart disease, neurological illness, liver or kidney problems, blood disorders [e.g. sickle cell disease, clotting or bleeding issues] |  |  |
| Do you have any allergies? E.g. food, medication or latex |  |  |
| Have you, or a first degree relative (parents, brother, sister, or child), ever experienced any mental health issues, even mild anxiety, or depression? |  |  |
| Do you have, or have you had, a condition that could impair your immune system?E.g. HIV / AIDS, blood cancer |  |  |
| In the last 12 months, have you taken any medication or had treatment that could impair your immune system? E.g. chemotherapy, radiotherapy, high dose steroids |  |  |
| Have you ever had any surgery? E.g. open-heart surgery, transplant surgery, spleen or thymus gland removal |  |  |
| Are you receiving regular treatment or follow up with your GP / hospital specialist? |  |  |
| Do you have any disability or mobility problems? |  |  |
| Do you, or a first degree relative (parents, brother, sister or child), have epilepsy or seizures? |  |  |
| Have you, or anyone in your family, ever had a severe reaction to a vaccine or malaria medication? |  |  |
| Are you or your partner pregnant or planning a pregnancy? |  |  |
| Are you breast feeding? (if applicable) |  |  |

If you answered yes to any of the questions above, please provide details here with any other important information regarding your health, including problems experienced with previous travel:

Please give details of any medication you are taking, including prescribed / self-treatment / over- the-counter remedies and contraception. (If on multiple medications please attach a list, if possible, from your GP).

|  |  |
| --- | --- |
| NAME OF MEDICATION | DOSE / FREQUENCY |
|  |  |

# Babies and children only

|  |  |
| --- | --- |
| Weight: | Date: |

**Vaccine history**

If you have received vaccinations elsewhere which will not be in our clinic records, please provide details here.

|  |  |  |  |
| --- | --- | --- | --- |
|  | DATE(S) OF VACCINATION | DATE(S) OF VACCINATIONUNKNOWN | NOTES |
| BCG |  |  |  |
| Cholera |  |  |  |
| COVID-19 |  |  |  |
| Diphtheria / Tetanus / Polio |  |  |  |
| Hepatitis A |  |  |  |
| Hepatitis A / B |  |  |  |
| Hepatitis A / Typhoid |  |  |  |
| Hepatitis B |  |  |  |
| Japanese encephalitis |  |  |  |
| Influenza |  |  |  |
| Meningitis ACWY |  |  |  |
| MMR |  |  |  |
| Rabies |  |  |  |
| Tick-borne encephalitis |  |  |  |
| Typhoid |  |  |  |
| Yellow fever |  |  |  |
| Other: |  |  |  |

|  |  |  |
| --- | --- | --- |
| RISK MANAGEMENT CHECKLIST | DISCUSSEDP✓ | COMMENTS |
| 1. Medical preparation, (including pre-existing conditions) |  |  |
| 2. Journey risks |  |  |
| 3. Personal safety / accidents / injuries |  |  |
| 4. Environmental risks |  |  |
| 5. Food & water safety /travellers’ diarrhoea |  |  |
| 6. Vector-borne riskse.g. dengue, Zika |  |  |
| 7. Malaria ABCD (record medication in table below): |  |  |
| 8. Rabies & animal bite |  |  |
| 9. Sexual health / blood-borne viruses |  |  |
| 10. Skin / sun health |  |  |
| 11. Psychological health |  |  |
| 12. FGM |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ADVISED | DECLINED | GIVEN |  | ADVISED | DECLINED | GIVEN |
| Cholera |  |  |  | MMR |  |  |  |
| Diphtheria/tetanus/polio |  |  |  | Rabies |  |  |  |
| Hepatitis A |  |  |  | Typhoid |  |  |  |
| Hepatitis B |  |  |  | Yellow fever |  |  |  |
| Japanese encephalitis |  |  |  | Influenza |  |  |  |
| Meningitis ACWY |  |  |  | Other: |  |  |  |
| Tick-borne encephalitis |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Childhood / UK vaccination programme up-to-date?** | Yes | No |

# Antimalarial medication discussed today\*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | RECOMMENDED | PRESCRIBEDTODAY | DECLINED | REFERREDELSEWHERE |
| Atovaquone & proguanil |  |  |  |  |
| Chloroquine & proguanil |  |  |  |  |
| Doxycycline |  |  |  |  |
| Mefloquine |  |  |  |  |
| Emergency standby |  |  |  |  |

Any other advice or comments:

Source of information used to advise traveller (e.g. TravelHealthPro):

\*Local guidelines for record keeping should be followed

**NAME OF HEALTH PROFESSIONAL: SIGNATURE OF HEALTH PROFESSIONAL: DATE OF CONSULTATION:**