**TRAVEL RISK ASSESSMENT FORM** – To be completed and sent in 3 days prior to appointment.

|  |  |
| --- | --- |
| Name:  | Your country of origin:  |
|  | Date of birth:  |
|  | Male [ ]  Female [ ]  Non-binary [ ]  |
| 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.  |   |   |   |
| What modes of transport will you be using? 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 [ ]  Business trip [ ]  Cruise ship trip [ ]  Camping/hostels [ ]  Expatriate [ ]  Safari [ ]  Adventure [ ]  Volunteer work [ ]  Pilgrimage [ ]  Diving [ ]  Healthcare worker [ ]  Medical tourism [ ]  Visiting friends/family  |
|  Additional information: |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY**  |
|   | **YES** | **NO** | **DETAILS**  |
| Are you fit and well today  | [ ]  | [ ]  |   |
| Any allergies including food, latex, medication  | [ ]  | [ ]  |   |
| Have you, or anyone in your family, had a severe reaction to a vaccine or malaria medication before?  | [ ]  | [ ]  |   |
| Tendency to faint with injections  | [ ]  | [ ]  |   |
| Any surgical operations in the past, including e.g. open-heart surgery, spleen or thymus gland removal?  | [ ]  | [ ]  |   |
| Recent chemotherapy/radiotherapy/organ transplant  | [ ]  | [ ]  |   |
| Anaemia  | [ ]  | [ ]  |   |
| Bleeding /clotting disorders (including history of DVT)  | [ ]  | [ ]  |   |
| Heart disease (e.g. angina, high blood pressure)  | [ ]  | [ ]  |   |
| Diabetes  | [ ]  | [ ]  |   |
| Additional needs and/or disability  | [ ]  | [ ]  |   |
| Epilepsy/seizures (or in a first degree relative?)  | [ ]  | [ ]  |   |
| Gastrointestinal (stomach) complaints  | [ ]  | [ ]  |   |
| Liver and or kidney problems  | [ ]  | [ ]  |   |
| HIV/AIDS  | [ ]  | [ ]  |   |
| **Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)? |
|  |
|   | **YES** | **NO** | **DETAILS** |
| Immune system condition e.g. blood cancer  |[ ] [ ]   |
| Mental health issues (including anxiety, depression)  |[ ] [ ]   |
| Neurological (nervous system) illness  |[ ] [ ]   |
| Respiratory (lung) disease  |[ ] [ ]   |
| Rheumatology (joint) conditions  |[ ] [ ]   |
| Spleen problems  |[ ] [ ]   |
| Any other conditions?  |[ ] [ ]   |
| Are you or your partner pregnant or planning a pregnancy?  |[ ] [ ]   |
| Are you breast feeding (if applicable)  |[ ] [ ]   |
| Have you or anyone in your family undergone FGM / been cut / circumcised  |[ ] [ ]   |
| **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 |
| COVID-19 (dates, brand etc.) |
| Malaria Tablets |

 **Any additional information**