Haden Vale Medical Practice

Travel Risk Assessment Form

Instructions

1. Fill in one form for each traveler.

2. Complete form with as much information about your previous vaccinations and travel destination/itinerary as possible.

Patient Details:
Name:
Address:
Tel No:
DOB:

Specific Countries to be Visited	Date of Departure	Length of Stay
1.		
2.		
3.		

Please tick as appropriate below to best describe your trip

1.Type of Trip	Business	Pleasure	Other
2.Holiday Type	Package	Self-Organised	Backpacking
	Camping	Cruise Ship	Trekking
3. Accommodation	Hotel	Relatives/Family Home	Other
4.Travelling	Alone	With Family/Friend	In a Group
5.Staying in area which is	Urban	Rural	
6.Planned Activities	Safari	Adventure	Other

Will you be away from medical help at your destination, if so for how long and how remote?

Personal Medical History
Do you have any recent or past medical history of note? (Including Diabetes, heart or lung conditions)
List any current or repeat medications:
Do you have any allergies e.g. to eggs, antibiotics, nuts?
Have you ever had a serious reaction to a vaccine given to you before?
Does having injections make you feel faint?
Do you or any close family member have epilepsy?
Do you have a history of mental illness including depression or anxiety?

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
Women only: Are you pregnant or planning pregnancy or breastfeeding?
Have you taken out travel insurance and if you have a medication condition, informed the insurance company about this?
Please write below any further information which may be relevant:

Vaccination History Have you ever had any of the following vaccinations/malaria tablets and I so when?

Tetanus		Polio		Diphtheria		Other, Please State	
Typhoid		Hepatitis A		Hepatitis B			
Meningitis		Yellow Fever		Influenza			
Rabies		Jap B Enceph		Tick Bourne			

I can confirm that the above information to be correct to the best of my knowledge Signed……………………………   Date……………………… (parent if under 16)

<u>For Office use only</u>

Travel Vaccines recommended for the trip

Disease Protection	**Yes**	**Confirmed**	**Required**	**Vaccine Given**	**Batch Number**	**Date**
Hepatitis A						
Hepatitis B						
Typhoid						
Cholera						
Tetanus						
Diphtheria						
Polio						
Meningitis ACWY						
Yellow Fever						
Rabies						
Japanes B Encephalitis						
Other						

Travel advice and leaflets given

Food and water and personal hygiene advice	Traveller's Diarrhoea	Hepatitis B and HIV
Insect Prevention	Animal Bites	Accidents
Insurance	Air Travel	Sun and Heat Protection
Other		

Malaria Prevention advice and malaria chemoprophylaxis
Malaria Chemoprophylaxis required: Weight(child)

I have no reason to think I might be pregnant. 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.	
Signed: (Parent if under 16yrs)	**Date:**

The patient named above can be given__________________________vaccination by subcutaneous or intramuscular injection.

By__________________________(nurse)

Authorised by_____________________________(Doctor or independent prescriber)

Vaccination Given:	**Signed by:**	**Position:**	**Date :**