# HEALTHCARE ELECTIVE TRAVEL RISK ASSESSMENT FORM (V3)

| OFFICE USE ONLY: Date of Travel ………………………………………………………………………………… | Cleared by: | ☐ Travel Nurse ☐ Travel Doctor | ☐ Admin ☐ Certificate issued |
|---|---|---|---|

**SECTIONS 1-3 TO BE COMPLETED BY STUDENT**
**(You must complete sections 1, 2 & 3 before 1st appointment and print a copy)**

## (1) PERSONAL DETAILS

| ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx | **Name** | | **DOB** | |
|---|---|---|---|---|
| ☐ Male ☐ Female ☐ Other | **Address** | | **Registered GP Surgery** | |
| | **Postcode** | | **Phone No (mobile)** | |

| ****FOR ALL NON-REGISTERED PATIENTS**** | |
|---|---|
| 1. Consent: Can we access your NHS GP record? ***NB/If not, you must bring an immunisation history with you*** | ☐ Yes ☐ No |
| 2. Consent: Can we share information back to your GP? | ☐ Yes ☐ No |

## (2) ELECTIVE TRAVEL PLANS (provide as much information as possible)

| Travelling to: | Arrival date | Departure date | Describe each location ie *urban, rural, jungle, coastal, altitude* |
|---|---|---|---|
| **1)** | | | |
| **2)** | | | |
| **3)** | | | |

## (3) ADDITIONAL TRAVEL PLANS

| Do you plan on travelling anywhere either before or after your elective? ☐ Yes ☐ No | **If yes, where?** (please state all countries including dates, location, accommodation and type of activities) |
|---|---|

*****FOLLOWING SECTIONS TO BE COMPLETED BY TRAVEL HEALTH NURSE ONLY*****

## MEDICAL HISTORY

**Any history of:**
- ☐ Epilepsy
- ☐ Psoriasis
- ☐ Kidney/Liver Problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Immunosuppression
- ☐ Steroid Therapy
- ☐ Anxiety/Depression

**Allergies:**

**Any allergic reaction to egg or gelatine:** ☐ Yes ☐ No

**Medical History**
**Current:**

**Previous:**

**Medications:**

**FEMALE TRAVELLERS ONLY**
**Is there any risk of pregnancy?** ☐ Yes ☐ No
**Is patient planning pregnancy?** ☐ Yes ☐ No
**LMP Date** ………………………………………

**Possible contraindications to any vaccines/malaria prophylaxis:** ☐ Yes ☐ No

## MALARIA PROPHYLAXIS

☐ Bite Avoidance ☐ Repellents ☐ Nets ☐ Clothing ☐ Prophylaxis ☐ S/S Malaria ☐ Malaria Map

# HEALTHCARE ELECTIVE TRAVEL RISK ASSESSMENT FORM (V3)

## VACCINATION HISTORY & SCHEDULE

| | 1 | 2 | 3 | 4 | Notes |
|---|---|---|---|---|---|
| BCG | | | | | |
| DTP | | | | | |
| *Meningitis ACWY | | | | | |
| MMR | | | | | |
| Hepatitis A | | | | | |
| Typhoid | | | | | |
| *Hepatitis B | | | | | |
| *Rabies | | | | | |
| *Yellow Fever | | | | | |
| *Japanese Encephalitis | | | | | |
| *Tickborne Encephalitis | | | | | |
| Influenza | | | | | |
| Pneumococcal | | | | | |
| Shingles | | | | | |
| Covid | | | | | |
| Other | | | | | |
| Other | | | | | |

## PATIENT SPECIFIC DIRECTION (PSD) AUTHORISATION STATEMENT

Following completion of the Travel Risk Assessment, I hereby authorise the use of the following vaccines as a PSD:

- ☐ Meningitis ACWY
- ☐ Hepatitis B
- ☐ Rabies
- ☐ Yellow Fever
- ☐ Japanese Encephalitis
- ☐ Tickborne Encephalitis

**Doctor Name**.................................................................................................

**Doctor Signature**.............................................**Date**......................................

*Once GP signed > Reception to scan, file to emis and destroy paper copy*

## PATIENT CONSENT

Are you well today? ☐ Yes ☐ No

I confirm that I understand all the advice given to me today

**Patient signature**..........................................................**Date**................................

**Nurse signature**...............................................................

**Date of risk assessment** ....................................................