HEALTHCARE ELECTIVE TRAVEL RISK ASSESSMENT FORM (V4)

OFFICE USE ONLY: Date of Travel ……	Cleared by: ☐ Travel Nurse ☐ Admin ☐ Travel Doctor ☐ 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 ☐ Male ☐ Female ☐ Other	**Name**		**DOB**	
	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:

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

FEMALE TRAVELLERS ONLY
Is there any risk of pregnancy?
☐ Yes ☐ No

Is patient planning pregnancy?
☐ Yes ☐ No

LMP Date ……

MALARIA PROPHYLAXIS

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

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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					
Cholera					
Dengue Fever					
Chikungunya					
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
- ☐ Chikungunya

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 ……