TRAVEL RISK ASSESSMENT FORM – ideally to be completed by travellers prior to appointment.

Name:	Your country of origin:
	Date of birth:
	Male □ Female □
E mail:	Telephone 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.			

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	Additional information
□ Business trip	□ Cruise ship trip	□ Camping/hostels	
□ Expatriate	□ Safari	□ Adventure	
□ Volunteer work	□ Pilgrimage	□ Diving	
□ Healthcare worker	□ Medical tourism	□ Visiting friends/family	

PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY

	YES	NO	DETAILS
Are you fit and well today			
Any allergies including food, latex, medication			
Severe reaction to a vaccine before			
Tendency to faint with injections			
Any surgical operations in the past, including e.g. your spleen or thymus gland removed			
Recent chemotherapy/radiotherapy/organ transplant			
Anaemia			
Bleeding /clotting disorders (including history of DVT)			
Heart disease (e.g. angina, high blood pressure)			
Diabetes			
Disability			
Epilepsy/seizures			
Gastrointestinal (stomach) complaints			

Liver and or kidney problems			
HIV/AIDS			
Immune system condition			

	YES	NO	DETAILS
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
Women only			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			
Have you undergone FGM / been cut / circumcised			

Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?

For discussion when risk assessment is performed within your appointment:

I have no reason to think that 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 vaccinations being given:

Signed:……Date:……

PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST. IF SO WHEN?					
Tetanus/polio/diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies		Japanese encephalitis		Tick borne encephalitis	
Yellow fever		BCG		Other	
Malaria Tablets					

For Office Use Only						
Patient Name:						
Travel risk assessment performed: Yes [ ] No [ ]						
Travel Vaccines recommended for this trip						
Disease protection	Yes		No		Further information	
Hepatitis A						
Hepatitis B						
Typhoid						
Cholera						
Tetanus						
Diphtheria						
Polio						
Meningitis ACWY						
Yellow Fever						
Rabies						
Japanese B Encephalitis						
Other						
Travel advice and leaflets given as per travel protocol						
Food water & personal hygiene advice		Travellers diarrhoea		Hepatitis B & HIV		
Insect Bite prevention		Animal bites		Accident		
Insurance		Air travel		Sun & heat protection		
Wesites	Travel Record card supplied					
	Other					
Malaria prevention advice and malaria chemoprophylaxis						
Chloroquine and proguanil		Atovaquone + proguanil (Malarone				
Chloroquine		Mefloquine				
Doxycycline		Malaria advice leaflet given				
Further information						
eg weight of child:						
Authorised for Patient Specific Direction (PSD) Use						
Name: Signature: Date:						