

Bosworth Medical Centre

TRAVEL RISK ASSESSMENT FORM

Please complete this form prior to your travel appointment and bring with you to your appointment

Personal details						
Name:			Date of birth:			
			Male <input type="checkbox"/> Female <input type="checkbox"/>			
Easiest contact telephone number						
E mail						
Dates of trip						
Date of Departure						
Return date or overall length of trip						
Itinerary and purpose of visit						
Country to be visited		Length of stay		Away from medical help at destination, if so, how remote?		
1.						
2.						
3.						
Please tick as appropriate below to best describe your trip						
1. Type of trip	Business	<input type="checkbox"/>	Pleasure	<input type="checkbox"/>	Other	<input type="checkbox"/>
2. Holiday type	Package	<input type="checkbox"/>	Self organised	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>
	Camping	<input type="checkbox"/>	Cruise ship	<input type="checkbox"/>	Trekking	<input type="checkbox"/>
3. Accommodation	Hotel	<input type="checkbox"/>	Relatives / family home	<input type="checkbox"/>	Other	<input type="checkbox"/>
4. Travelling	Alone	<input type="checkbox"/>	With family / friend	<input type="checkbox"/>	In a group	<input type="checkbox"/>
5. Staying in area which is	Urban	<input type="checkbox"/>	Rural	<input type="checkbox"/>	Altitude	<input type="checkbox"/>

6. Planned activities	Safari		Adventure		Other		
Personal medical history							
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions, thymus disorder) – Please write this information on blank space at page 4							
List any current or repeat medications							
Do you have any allergies for example to eggs, antibiotics, nuts ?							
Have you ever had a serious reaction to a vaccine given to you before?							
Does having an injection make you feel faint?							
Do you or any close family members have epilepsy?							
Do you have any history or mental illness including depression or anxiety							
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?							
<i>Women only:</i> Are you pregnant or planning pregnancy or breast feeding?							
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about his?							
Please write below any further information which may be relevant							

Vaccination History					
Have you ever had any of the following vaccinations / malaria tablets and if so when?					
Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
Other					
Malaria tablets					

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 vaccines being given.

Please note that you may be charged for your vaccinations as they may not be available as an NHS service.

Signed _____ Date _____

For official use			
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 and personal hygiene advice		Travellers' diarrhoea	Hepatitis B and HIV
Insect bite prevention		Animal bites	Accidents
Insurance		Air travel	Sun and heat protection
Websites		Travel Record card supplied	

	OTHER
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MALARIA PREVENTION ADVICE and MALARIA CHEMOPROPHYLAXIS

Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

FUTHER INFORMATION
e.g. weight of child

Signed by: _____ **Position:** _____ **Date:** _____

Now scan this form into the patient's record on the computer for evidence of best practice