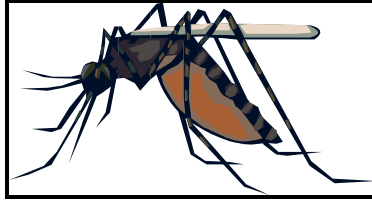


CHARLES STREET SURGERY
YELLOW FEVER VACCINATION CENTRE



YELLOW FEVER TRAVEL RISK ASSESSMENT

As Yellow Fever is a live vaccine it is not suitable for everyone. Before we are able to administer the vaccine we need to make sure it is safe for you. Instructions on how to proceed are contained in the following pages, however, please first of all read the list below and if any of these items apply to you please discuss them with your own doctor or practice nurse before you have the vaccine.

- You are pregnant or are breast-feeding
- Aged below 9 months old
- Allergic to eggs
- You have a suppressed immune system, possibly caused by;
 - Radiotherapy
 - Chemotherapy
 - Large dose of steroids (40mgs prednisolone daily for 1 week or more, or must wait 3 months before having live vaccine)
 - Thymus gland disorder including Myasthenia Gravis thymoma, thymectomy & DiGeorge's Syndrome.
 - HIV infected
 - Tablets for Crohns Disease – Mothotrexate, Azathioprine.
 - Rheumatoid Arthritis
 - Transplant surgery including bone marrow
 - Aged 60 years or over
- You are unwell / have a temperature
- Have had a bad reaction to a previous vaccine
- Have an allergy to any of the vaccine components

Charles Street Surgery Yellow Fever Centre

TRAVEL RISK ASSESSMENT FORM

INSTRUCTIONS FOR COMPLETION:

- Patient to fully complete pages 1 and 2 and pass to own GP or own Practice Nurse
- Your own GP or Practice Nurse to provide health travel advice and fully complete page 3.

THEN:

- Bring to Charles Street Surgery with payment by cash before an appointment can be made for your Yellow Fever Vaccination. Without this form you will be referred back to your own practice. Check with Charles Street for the current fee amount.

NOTE:

- Charles Street Surgery does not provide a Yellow Fever Vaccination Service to patients registered elsewhere who are over 60 years of age.

Personal details						
Name:			Date of birth:			
Age:			Male []		Female []	
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	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Other	<input type="checkbox"/>

Past Vaccination History					
Have you ever had any of the following vaccinations / malaria tablets and date of vaccination?					
Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		TickBorne Enceph	
Other ie BCG					
Malaria tablets					

For discussion when risk assessment is performed within your appointment:

Do you suffer from any of the following:

Diabetes		Cancer	
Angina		Blood Disorders	
Heart Failure		Allergies	
Heart Disease		Allergic to Eggs	
Lung Disease		Pregnant	
Asthma		Breast Feeding	
Liver Disease		Mental Illness	
Kidney Disease		Depression	
Epilepsy			

Current Medications:

If you have a raised temperature or are unwell you should cancel your appointment for the yellow fever vaccination.

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.

Signed _____ Date _____

Registered GP Practice Use only: GP or Practice Nurse.**Patient Name:**

Travel risk assessment performed by own practice Yes [] No []

TRAVEL VACCINES RECOMMENDED FOR THIS TRIP

Disease protection	Yes	No	Given or reasons for omission
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
Organisations consulted www.nathnac.org www.travax.nhs.uk	Travel Record card supplied	

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

Practice Stamp:**Signed by:****Position:****Date:****Charles Street Use Only**

Vaccine name: Stamaril

Batch No:

Site :

Nurse Signature:

Patient Signature:

Date :