

Charles Street Surgery

TRAVEL RISK ASSESSMENT FORM

INSTRUCTIONS FOR COMPLETION:

- Patient to fully complete pages 1 and 2. Provide vaccination information if known otherwise we will obtain from our records

THEN:

- Bring to Charles Street Surgery for your appointment.

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		Pleasure		Other	
2. Holiday type	Package		Self organised		Backpacking	
	Camping		Cruise ship		Trekking	
3. Accommodation	Hotel		Relatives / family home		Other	
4. Travelling	Alone		With family / friend		In a group	
5. Staying in area which is	Urban		Rural		Altitude	
6. Planned activities	Safari		Adventure		Other	

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 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 _____

Practice Use only: GP or Practice Nurse.

Patient Name:

Travel risk assessment performed 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:

Batch No:

Site :

Nurse Signature:

Patient Signature:

Date :