

TRAVEL RISK ASSESSMENT FORM

Your travel form needs to be submitted 6 – 8 weeks prior to your departure date. You will need to complete the travel assessment form below and hand this into the Treatment room reception area. You will then receive a phone call or text message as soon as the assessment form has been processed by our Practice Nurses.

WE ARE UNABLE TO OFFER LAST MINUTE APPOINTMENTS.

If your departure date is **less than 4 weeks** we may not be able to process your assessment form and you may be advised to attend a private travel clinic in order to receive your travel vaccinations.

Name:		Your country of origin:		
		Date of birth:		
		Male <input type="checkbox"/> Female <input type="checkbox"/>		
Address:		Telephone number:		
		Mobile 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				
<input type="checkbox"/> Holiday <input type="checkbox"/> Staying in hotel <input type="checkbox"/> Backpacking <u>Additional information</u> <input type="checkbox"/> Business trip <input type="checkbox"/> Cruise ship trip <input type="checkbox"/> Camping/hostels <input type="checkbox"/> Expatriate <input type="checkbox"/> Safari <input type="checkbox"/> Adventure <input type="checkbox"/> Volunteer work <input type="checkbox"/> Pilgrimage <input type="checkbox"/> Diving <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Medical tourism <input type="checkbox"/> 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)?

--

PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST					
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					