TR 01

TRAVEL RISK ASSESSMENT FORM

Please complete this form prior to your travel appointment and return to reception

Personal details	
Name:	**Date of birth:** **Male** ☐ **Female** ☐
Easiest contact telephone number **E mail**	
Address	
Dates of trip	
Date of Departure	
Return date or overall length of trip	
Itinerary and purpose of visit	

Country to be visited *Please specify areas 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	☐

Personal medical history
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)
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?
Women only: 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?
Smoking Status: Do you smoke Ex Smoker If yes how many?
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.

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 ☐			

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: Nurse** **Date:**

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