**Woodlands Family Practice**

# TRAVEL RISK ASSESSMENT FORM

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

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| **Personal details** |
| **Name:** | **Date of birth:****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, exact location/region** | **Length of stay** | **City or rural, 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/Trekking |  |
| Safari |  | Diving |  | School Trip |  |
| Camping/Hostels |  | Cruise ship |  | Healthcare or Volunteer work |  |
| **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, thymus disorder, bleeding or clotting problems) |
| List any current or repeat medications |
| Do you have any allergies for example to food, latex, medications? |
| Have you ever had a serious reaction to a vaccine given to you before?  |
| Does having an injection make you feel faint? |
| Do you plan to travel again in the future? |
| 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? |
| Please write below any further information which may be relevant |

|  |
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| **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 |  |
| Pneumococcal |  | BCG |  | Cholera |  |
| 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 \_\_\_\_\_\_\_

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| **For official use****Patient Name:**  |
| Travel risk assessment performed Yes [ ] No [ ]   |
| **TRAVEL VACCINES RECOMMENDED FOR THIS TRIP**  |
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|  |  |  |  |
| --- | --- | --- | --- |
| **Disease protection** | **Yes** | **No** | **Further information** |
| Hepatitis A  |  |  |  |
| Hepatitis B  |  |  |  |
| Typhoid |  |  |  |
| Cholera |  |  |  |
| Tetanus |  |  |  |
| Diphtheria |  |  |  |
| Polio |  |  |  |
| Meningitis ACWY |  |  |  |
| Yellow Fever |  |  |  |
| Rabies |  |  |  |
| Japanese B Encephalitis |  |  |  |
| Other |  |  |  |
|  |  |  |  |

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| MALARIA PREVENTION ADVICE & 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 |