**Woodlands Family Practice**

# 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** | | | | | | | | | | | |
| **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 | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 \_\_\_\_\_\_\_

|  |
| --- |
| **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 |  |  |  | |  |  |  |  | |
| 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 |