

# TRAVEL RISK ASSESSMENT FORM

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



Countesthorpe  
Health Centre

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		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	<input type="checkbox"/>	Pleasure	<input type="checkbox"/>	Other	<input type="checkbox"/>
	2. Holiday type	Package	<input type="checkbox"/>	Self organised	<input type="checkbox"/>	Backpacking
	Camping	<input type="checkbox"/>	Cruise ship	<input type="checkbox"/>	Trekking	<input type="checkbox"/>
3. Accommodation	Hotel	<input type="checkbox"/>	Relatives / family home	<input type="checkbox"/>	Other	<input type="checkbox"/>

<b>4. Travelling</b>	Alone		With family / friend		In a group	
<b>5. Staying in area which is</b>	Urban		Rural		Altitude	
<b>6. Planned activities</b>	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 )

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 feint?

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?

Please write below any further information which may be relevant

<b>Vaccination History</b>					
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 \_\_\_\_\_

<b>For official use</b>			
<b>Patient Name:</b>			
Travel risk assessment performed Yes [ ] No [ ]			
<b>TRAVEL VACCINES RECOMMENDED FOR THIS TRIP</b>			
<b>Disease protection</b>	<b>Yes</b>	<b>No</b>	<b>Further information</b>
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			
<b>TRAVEL ADVICE AND LEAFLETS GIVEN AS PER TRAVEL PROTOCOL</b>			

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:**

**Date:**

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