**Highgate Medical Centre**

**TRAVEL RISK ASSESSMENT FORM**

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

|  |  |  |
| --- | --- | --- |
| **Personal details** | | |
| **Name:** | | **Date of birth: Female [ ]** |
| **Telephone number** | | |
|  | | |
|  | | |
| **Date of Departure** | | |
| **Return date / 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 Pleasure Other** | |
| **2. Holiday type** | **Package Self organised Backpacking** | |
| **Camping Cruise ship Trekking** | |
| **3. Accommodation** | **Hotel Relatives / Other family home** | |
| **4. Travelling** | **Alone With family / In a group friend** | |
| **5. Staying in area which is** | **Urban Rural Altitude** | |
| **6. Planned activities** | **Safari Adventure Other** | |

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* 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 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?
* 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 Ft | | 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 travellers’ diarrhoea  personal hygiene advice | Hepatitis B and HIV | |  |
| Accidents | Sun and heat protection | | |
| Insect bite prevention | Animal bites | | |
| travel Insurance | Air travel | | |
| Websites Travel Record card OTHER | supplied | |  |
| 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