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Travel Risk Assessment Form

Please complete this form and return it to Reception as soon as possible, at least 24 hours before you appointment time with the travel Nurse. Please be aware that we cannot guarantee you an appointment if you contact us less than a month before you travel.

Personal details						
Name:			Date of Birth: Male ☐ Female ☐			
Contact Telephone Number:						
E-mail address:						
Dates of Trip -						
Date of Departure:						
Return Date or overall length of trip:						
Itinerary or Purpose of Visit -						
Country to be visited (if possible, please include town/city, region/area)		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 -						
Type of Trip	Business		Pleasure		Other	
Holiday Type	Package		Self-organised		Backpacking	
	Camping		Cruise ship		Trekking	
Accommodation	Hotel		Relatives/Family Home		Other	
Travelling	Alone		With Family/friend		In a group	
Staying in are which is	Urban		Rural		Altitude	
Planned activities	Safari		Adventure		Other	

Personal Medical History

1. Do you have any recent medical history of note? This includes diabetes, heart or lung conditions, thymus disorder etc. Yes ☐ No ☐

   If yes, please give details ……..

2. Are you fit and well today? Yes ☐ No ☐

3. List of current or repeat medications:

   …….. …….. ……..

   …….. …….. ……

4. Do you have any allergies, for example to food (eggs, nuts) latex, medication (antibiotics)? Yes ☐ No ☐

   If yes, please give details
   ……

5. Have you ever had a serious reaction to a vaccine given to you before? Yes ☐ No ☐

   If yes please give details ……

6. Does having an injection make you feel faint? Yes ☐ No ☐

7. Do you or any close family member have epilepsy? Yes ☐ No ☐

   If yes please give details ……

8. Do you have any history of mental illness including depression or anxiety? Yes ☐ No ☐

   If yes please give details……

9. Have you recently undergone radiotherapy, chemotherapy, steroid treatment or any immune suppressant drugs? Yes ☐ No ☐

   If yes please give details……

10. Women only – Are you pregnant or planning pregnancy or breast feeding? Yes ☐ No ☐

11. Have you taken out travel insurance? If you have a medical condition have you informed the insurance company about this? Yes ☐ No ☐

If yes please give details……

12. Please give any further information that may be relevant, including any future travel plans.

……
……
……
……

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 and I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask question. I consent to the vaccines being given after discussion with the practice nurse.
Please be aware that there is a fee for certain vaccinations.

Signed:……
Date:…….

Name (printed)…….

TRAVEL RISK MANAGEMENT FORM

FOR HEALTH PROFESSIONAL USE ONLY IN CONJUNCTION with TRAVEL RISK ASSESSMENT FORM

Patient Name: **dob:**

Childhood immunisation history checked:

Additional information:

National database consulted for travel vaccines recommended for this trip and malaria chemoprophylaxis (if required): **NaTHNaC:** **TRAVAX:** **Other:**

Disease protection advised	**Yes**	**Disease protection advised**	**Yes**	**Malaria Chemoprophylaxis Recommendation**	**Yes**
BCG/Mantoux		Influenza		Atovaquone/proguanil	
Cholera		Meningitis ACWY		Chloroquine only	
Dip/tetanus/polio		MMR		Chloroquine and proguanil	
Hepatitis A		Rabies		Doxycycline	
Hepatitis B		TBE		Mefloquine	
Hepatitis A+B		Typhoid		Proguanil only	
Hepatitis A + Typhoid		Yellow fever		Emergency standby	
Japanese encephalitis		Other		Weight of child:	

Vaccine and General Travel Advice required/provided

Potential side effects of vaccines discussed Patient Information Leaflet (PIL) from packaging or from www.medicines.org.uk/emc/ given	

Patient consent for vaccination obtained: verbal ☐ written ☐

Post vaccination advice given: verbal ☐ written ☐

General travel advice leaflet given (all topics below in the surgery/clinic advice leaflet) and patient asked to read entire leaflet due to insufficient time to advise verbally on every topic: **Yes / No**

Items ticked below indicate topics discussed specifically within the consultation:

Prevention of accidents		Mosquito bite prevention	
Personal safety and security		Malaria prevention advice	
Food and water borne risks		Medical preparation	
Travellers' diarrhoea advice		Sun and heat advice	
Sexual health & blood borne virus risk		Journey/transport advice	
Rabies specific advice		Insurance advice	

Other specific specialised advice / information given on:

e.g.smoking advice for a long haul flight; altitude advice; prevention of schistosomiasis etc.

Source of advice used for further information : NaTHNaC TRAVAX Other

OR no additional specialised advice given ☐

Additional patient management or advice taken following risk assessment – for example

- Vaccine(s) patient declined following recommendation, and reason why
- Telephoned NaTHNaC or TRAVAX for advice or used Malaria Reference Laboratory fax service
- Contacted hospital consultant for specific information in respect of a complex medical condition
- Given appropriate advice in relation to pregnancy and planned conception if travelling to Zika risk area
- Identified specific nature/purpose of VFR travel

Authorisation for a Patient Specific Direction (PSD)

Following the completion of a travel risk assessment, the below named vaccines may be administered under this PSD to:

Name: **dob:**

Name, form & strength of medicine (generic/brand name as appropriate)	**Dose, schedule and route of administration**	**Start and finish dates**

Signature of Prescriber	**Date**

Post Vaccination administration

Vaccine details recorded on patient computer record (vaccine name, batch no., stage, site, etc.)	**Y / N**
SMS vaccines reminder or post card reminder service set up	**Y / N**
Travel record card supplied or updated:	**Y / N**
Travel risk management consultation performed by: (sign name and date)	