**Emsworth Surgery Travel Risk Assessment**

(must be completed prior to travel clinic appointment)

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| --- |
| Patient Name: ………………………………………………………………………………………Address: ……………………………………………………………………………………………..............................................................................................................................................……………………………………………………………………………………………………….Date of Birth: ………………………………………………………………………………………. |
| Dates of trip:…………………………………………………………………………………………Departure:……………………………………………………………………………………………Date of Appointment with nurse if already made………………………………………………….Overall length of trip: \_\_\_\_ days |
| Country to be visited | Length of stay | Malaria risk (Y/N) Vaccinations needed |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4  |  |  |
| 5 |  |  |
| 6 |  |  |

Please tick the descriptions which best describe your trip:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Trip Type | Holiday |  | Business |  | Other |  |
| Holiday Type | Package |  | Self Organised |  | Backpacking |  |
|  | Camping |  | Cruise Ship |  | Trekking |  |
| Accommodation | Hotel |  | Relatives / Family  |  | Other |  |
| Travelling | Alone |  | Family /Friend |  | In A Group |  |
| Area | Urban |  | Rural |  | Altitude |  |
| Planned Activity | Safari |  | Adventure |  | Other |  |

|  |
| --- |
| **Vaccination history**Have you ever had any of the following vaccinations and if so when? |
| Tetanus |  |  | Polio |  | Diphtheria |  |  |
| Typhoid |  |  | Hepatitis A |  | Hepatitis B |  |  |
| Meningitis |  |  | Yellow fever |  | Influenza |  |  |
| Rabies |  |  | Jap B Encephalitis |  | Tick Borne Encephalitis |  |  |

**Personal Medical History**

|  |  |  |
| --- | --- | --- |
| Do you have any recent past medical history of note? This includes diabetes, heart or lung conditions, thyroid disorder? | YES | NO |
| Please list any current medications (on reverse) or attach a repeat prescription printout. |  |  |
| Do you have any allergies? (Eg. eggs antibiotics or nuts?) |  |  |
| Have you ever had a serious reaction to a vaccine given before? |  |  |
| Has an injection ever made you feel faint? |  |  |
| Do you or any close family members have epilepsy? |  |  |
| Do you have any history of mental illness including depression or anxiety? |  |  |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |  |  |
| Women only: are you pregnant or planning or breast feeding? |  |  |
| Have you taken out travel insurance?  |  |  |
| If you have a medical condition, have you informed the insurance company about it? |  |  |
| Please give any further information that may be relevant, including any future travel plans. |  |  |

**Official use:**

**Travel vaccinations** recommended for this trip:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hepatitis A |  | Tetanus |  | Yellow fever |  |
| Hepatitis B |  | Diptheria |  | Rabies |  |
| Typhoid |  | Polio |  | Jap B Encep  |  |
| Cholera |  | Meningitis |  | Tick Borne Encephalitis |  |

**Malaria prophylaxis**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Chloroquine + proguanil |  | Malarone |  | Chloroquine |  |
| Mefloquine |  | Doxycycline |  | Advice leaflet |  |
| Patients weight \_\_\_\_\_\_\_\_kgI 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. I do not consent to be given\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and am aware that this is against medical advice.I have received information regarding my planned travel Signature Date: |

Charges

Please contact the surgery for charges or check on website.

 Feb 2014