

BILLERICAY MEDICAL PRACTICE

TRAVEL RISK ASSESSMENT FORM

Please complete this form and return it to reception as soon as possible, allowing 2-3 working days before your appointment with the travel nurse. Ideally we would like to see you six weeks before your trip.

Personal details						
Name:			Date of birth:			
Address:			Male <input type="checkbox"/> Female <input type="checkbox"/>			
Postcode:						
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 (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						
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	<input type="checkbox"/>
	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"/>
4. Travelling	Alone	<input type="checkbox"/>	With family / friend	<input type="checkbox"/>	In a group	<input type="checkbox"/>
5. Staying in area which is	Urban	<input type="checkbox"/>	Rural	<input type="checkbox"/>	Altitude	<input type="checkbox"/>
6. Planned activities	Safari	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Other	<input type="checkbox"/>

1. Are you suffering from any minor ailments? Yes No

If yes please give details

2. Do you have any long-term medical conditions? Yes No

If yes please give details

3. Do you have a history of epilepsy? . Yes No

If yes please give details

4. Have you ever experienced anxiety, depression or other psychological problems, which have required treatment? Yes No

If yes please give details

5. Have you had your spleen removed? Yes No

If yes please give details

6. Have you ever had a bad reaction to a vaccine? Yes No

If yes please give details

7. Do you have any other allergies, e.g. eggs? Yes No

If yes please give details

8. Are you taking any medication including the oral contraceptive pill, or have you been on antibiotics within the last 10 days? Yes No

If yes please give details

9. Do you smoke? Yes No

Have you ever smoked? Yes No

Are you an ex-smoker? Yes No

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 declare this information to be correct. 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:
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For official use			
Patient Name:			
Travel risk assessment performed?	Yes []	By:	
	No []	Date:	
Length of Appointment			
Appointment time span (eg: 2 – 3 weeks time)			
Additional comments			
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			
Malaria Prophylaxis			
Other			

Assessing nurse signature Date

Prescriber signature Date

Nurse administering vaccine signature Date