|  |  |
| --- | --- |
| Name:**TRAVEL RISK ASSESSMENT FORM-** **To be completed 6 weeks prior to travelling**  | Date of Birth |
| Male:  | Female: |
| Email: | Home Number: | Mobile Number: |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP, PLEASE FILL IN THE SECTION BELOW:** |
| Date of Departure: | Total Length of Trip: |
| Country To Be Visited | Exact Location Or Region | City or Rural | Length Of Stay  |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| Have you taken out travel Insurance for this trip? | Do you plan to travel abroad again in the future? |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY**  |
|  | Holiday |  | Healthcare Worker |  | Backpacking |  | Visiting Friends and Family. |
|  | Business Trip |  | Staying in a hotel |  | Camping/hostels | Additional information: |
|  | Expatriate |  | Cruise ship trip |  | Adventure |
|  | Volunteer Work |  | Pilgrimage |  | Diving |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** |
|  | Yes  | No  | Details |
| Any allergies including food, latex, medication? |  |  |  |
| Severe reaction to a vaccine before? |  |  |  |
| Tendency to faint with injections? |  |  |  |
| Any surgical operations in the past, including e.g. your spleen or thymus gland removed? |  |  |  |
| Recent chemotherapy/ radiotherapy/ organ transplant? |  |  |  |
| Anaemia? |  |  |  |
|  | Yes | No | Details |
| Bleeding/ Clotting disorders (including history of DVT)? |  |  |  |
| Heart disease (e.g. angina, high blood pressure)? |  |  |  |
| Diabetes? |  |  |  |
| Disability? |  |  |  |
| Epilepsy/seizures? |  |  |  |
| Gastrointestinal (stomach) complaints? |  |  |  |
| Liver and or kidney problems? |  |  |  |
| HIV/AIDS? |  |  |  |
| Immune system condition? |  |  |  |
| Mental health issues (including anxiety, depression)? |  |  |  |
| Neurological (nervous system) illness? |  |  |  |
| Respiratory (lung) disease? |  |  |  |
| Rheumatology (joint) conditions? |  |  |  |
| Spleen problems? |  |  |  |
| Any other conditions? |  |  |  |
| Are you pregnant? |  |  |  |
| Are you breast feeding? |  |  |  |
| Are you planning pregnancy while away? |  |  |  |
| Have you undergone FGM / been cut / circumcised? |  |  |  |
| ARE YOU CURRENTLY TAKING ANY MEDICATION? |
| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** |
|  | Tetanus/ Polio/ Diphtheria |  | Rabies |  | Hepatitis A |  | Influenza |
|  | Typhoid |  | Yellow Fever |  | Hepatitis B |  | Pneumococcal |
|  | Cholera |  | MMR |  | Japanese Encephalitis |  | Meningitis |
|  | Tick Borne Encephalitis |  | BCG |  | Malaria | Other: |
| Any Additional Information: |
| **FOR OFFICIAL USE ONLY** |
| Patient Name: | Date of Birth: | Travel risk assessment Performed? YES/NO |
| **TRAVEL VACCINES RECOMMENDED FOR THIS TRIP:** |
| Disease Protection | Yes | No  | Patient declined Vaccine | Vaccine name, dose & schedule for PSD |
| 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 Personal hygiene advice. |  | Insect Bite Prevention |  | Insurance |  | Websites |
|  | Travel record card Supplied |  | Travellers’ Diarrhoea |  | Animal Bites |  | Air Travel |
|  | Blood and bodily fluid infection risk e.g. Hep B |  | Accidents |  | Sun and heat protection  | Other: |
| **MALARIA PREVENTION ADVICE AND MALARIA CHEMOPROPHYLAXIS:** |
|  | Chloroquine and Proguanil |  | Chloroquine |  | Doxycycline |
|  | Atovaquone & Proguanil |  | Mefloquine |  | Malaria advice leaflet given |
| **FURTHER INFORMATION:** |
| **AUTHORISATION FOR PATIENT SPECIFIC DIRECTION (PSD) USE:** |
| Name:  | Signature: | Date: |