|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: | | |