TRAVEL RISK ASSESSMENT - MANAGEMENT & IMMUNISATION CONSENT FORM

At least 4 hours prior to attending your consultation, complete pages 1, 2 and 4 and email a scanned copy of the form to medsuite@lloyds.com. Please submit the original on appointment.

BLOSSOMS HEALTHCARE

Traveller's Personal Details:		
Title: Mr. ☐, Mrs. ☐, Ms. ☐, Miss ☐, Dr. ☐, Other:		
Name(s):	Surname(s):	
Gender: Male ☐ Female ☐	Date of Birth: / /19	Age:
Company Name:	Job Title:	
Work Email Address:	Pass Colour:	Pass Number:
Work Phone:	Home Phone:	Mobile Phone:
Postal Home Address:		
House No :	Town/City :	
Street :	County :	
Suburb :	Post Code :	
	UNITED KINGDOM	

Travelling Destination Details:				
Date leaving the UK :	/ / 20	**Date back in the UK:**	/ / 20	
Visiting Locations		**Date**		**Describe access to medical help in this destination:**
Country	**City/Area**	**Arrival**	**Departure**	
		/ / 20	/ / 20	
		/ / 20	/ / 20	
		/ / 20	/ / 20	
		/ / 20	/ / 20	
		/ / 20	/ / 20	
Overall length of stay abroad		days.		
Do you plan to travel abroad again in the next 2 years? If yes, state the potential destinations and dates.				

Travelling Information: [Please tick as many options applicable to best describe your trip].						
Type of Trip	Holidays / Pleasure		Business		Business & Pleasure	
	Visiting Relatives/Friends		Voluntary/Charity Work		Healthcare Work	
	Other		(specify):			
Holiday Type	Self-Organised		Organised by travel agent		Organised by employer	
	Cruise (whole trip)		Backpacking		Safari / Adventure	
	Other		(specify):			
Travelling with	Alone		Family members		Children	
	Colleagues / Associates		Friends		Group (unknown)	
	Other		(specify):			
Area of Accommodation	Urban (main cities)		Sub-urban (small towns)		Rural (remote villages)	
	Altitude / mountains		Forest / Desert		Jungle / Paddy Fields	
	Other Area		(specify):			
Type of Accommodation	Hotel		Rented Apartments/House		Hostel	
	Cruise Ship		Relatives/Friends House		Camping Sites (Tents)	
	Other		(specify):			
Planned Activities	Staying at hotel/resort		Business Meetings/Work		Sightseeing	
	Scuba / Sub-aqua Diving		Cruise (incorporated)		Sports (Golf, Rowing etc.)	
	Backpacking		Camping		Trekking / Climbing	
	Exploring Wildlife / Safari		Exposure to wild animals		Hunting / Fishing	
	Other Adventure(s)		(specify):			

TRAVEL RISK ASSESSMENT - MANAGEMENT & IMMUNISATION CONSENT FORM

At least 4 hours prior to attending your consultation, complete pages 1, 2 and 4 and email a scanned copy of the form to medsuite@lloyds.com. Please submit the original on appointment.

BLOSSOMS HEALTHCARE

Immunisation History:

Have you ever had any of the following inoculations and if so when? It is essential to state the dates for **all doses** received previously, of each vaccine, to specify completion of the immunisation schedules.

Disease	1st Dose	2nd Dose	3rd Dose
Hepatitis A	/ / 20	/ / 20	/ / 20
Hepatitis B	/ / 20	/ / 20	/ / 20
Typhoid Fever	/ / 20	/ / 20	/ / 20
Tetanus | Diphtheria | Polio	/ / 20	/ / 20	/ / 20
Cholera	/ / 20	/ / 20	/ / 20
Rabies	/ / 20	/ / 20	/ / 20
Yellow Fever	/ / 20	/ / 20	/ / 20
Japanese Encephalitis	/ / 20	/ / 20	/ / 20
Tick-borne Encephalitis	/ / 20	/ / 20	/ / 20
Meningitis (ACWY)	/ / 20	/ / 20	/ / 20
Tuberculosis (BCG)	/ / 20	/ / 20	/ / 20
Influenza	/ / 20	/ / 20	/ / 20
Other	/ / 20	/ / 20	/ / 20
Prophylaxis tablets against Malaria		/ / 20	/ / 20
Preventative tablets for Mountain/Altitude Sickness		/ / 20	/ / 20

Traveller's Medical History (Current & Past)

Condition / Illness	Yes	No	Condition / Illness	Yes	No	Condition / Illness	Yes	No
Asthma / COPD	☐	☐	Liver Disease	☐	☐	Epilepsy | Fits	☐	☐
Lung Disease	☐	☐	Diabetes	☐	☐	Neurological Disease	☐	☐
CardioVascular Disease	☐	☐	Arthritis | Gout	☐	☐	Mental Illness	☐	☐
Gastrointestinal Issues	☐	☐	Hormonal Disorders	☐	☐	Depression | Anxiety	☐	☐

Disability	☐	☐	(specify):
Are you pregnant?	☐	☐	Stage of Pregnancy: _____ weeks (+/- 2) Gestation Order: _____ Note any pregnancy complications:

Other Medical Condition	**Previous Surgical Procedures**

Known True Allergies:

	Yes	No
• Are you allergic to any antibiotics (specifically Neomycin or Polymyxin)?	☐	☐
• Have you had ever had a serious allergic reaction to a vaccine given to you before?	☐	☐
• Have you had ever had a serious allergic reaction to eggs or poultry?	☐	☐
• Are you allergic to any other medication, or food (e.g. nuts), or material (e.g. latex, plasters)	☐	☐

Please specify other allergies:

Do you Drink Alcohol? Yes ☐ No ☐	**Do you smoke?** Yes ☐ No ☐
____ units per day ☐ week ☐ occasionally ☐	____ cigarettes per day, for ____ years.

Current or Repeat Medication:

Drug Name	Dose	Route	Frequency

TRAVEL RISK ASSESSMENT - MANAGEMENT & IMMUNISATION CONSENT FORM

At least 4 hours prior to attending your consultation, complete pages 1, 2 and 4 and email a scanned copy of the form to medsuite@lloyds.com. Please submit the original on appointment.

CONSULTATION RECORDS ***[For official use – This page is to be completed by the clinician on appointment]***

Inoculations discussed/offered and agreed for this trip [complete as appropriate]								
Inoculation/Disease	**Recommended**		**To Be Considered**	**Agreed by Client**	**Declined by Client**	**Notes**		
	Yes	**No**						
Vaccines						**Brand**	**Batch**	**Expires**
Hepatitis A								- 201
Hepatitis B								- 201
Hepatitis A + B								- 201
Typhoid Fever								- 201
Hepatitis A + Typhoid F.								- 201
Tetanus | Diphtheria | Polio								- 201
Cholera								- 201
Rabies								- 201
Yellow Fever								- 201
Japanese Encephalitis								- 201
Tick-borne Encephalitis								- 201
Meningitis (ACWY)								- 201
Tuberculosis (BCG)								- 201
Influenza								- 201
Malarial Prophylaxis						**Quantity Prescribed**		
Atovaquone & Proguanil						Tablets		
Chloroquine & Proguanil						Tablets		
Chloroquine						Tablets		
Mefloquine						Tablets		
Doxycycline						Tablets		
Traveller's Diarrhoea Chemo - Prophylaxis/Treatment						**Quantity Prescribed**		
Ciprofloxacin 500mg						Tablets		
Mountain/Altitude Sickness Prophylaxis						**Quantity Prescribed**		
Acetazolimide 250mg						Tablets		
The entire cost of the consultation and the received inoculations is to be invoiced/changed to:								
Traveller (Self-Paid – Personal Trip)						Payment for **£** processed		
Traveller's Employer Company (Business Trip)						by		

Forthcoming Vaccination Dates ***[for the completion of immunisation schedules, as indicated/agreed]***			
Disease	**2nd Dose**	**3rd Dose**	**4th Dose**
Hepatitis A	/ / 20		
Hepatitis B	/ / 20	/ / 20	/ / 20
Rabies	/ / 20	/ / 20	
Japanese Encephalitis	/ / 20		
Tick-borne Encephalitis	/ / 20	/ / 20	
	/ / 20	/ / 20	
	/ / 20	/ / 20	
	/ / 20	/ / 20	

Items ticked below indicate topics discussed and information leaflets given during the consultation:					
Travel Health Websites		Air Travel Illness		Insect Bite Prevention	
Travel Insurance		Personal Hygiene & Safety		Malaria Prevention	
Medical Cover Abroad		Sun & Heat Protection		Animal Bite Mgment (Rabies)	
Vaccination Records Booklet		Foot & Water Precautions		Sexual & Blood Borne Virus Risk	
Yellow Fever Vaccin. Certificate		Traveller's Diarrhoea		Mountain / Altitude Sickness	
Bespoke "MASTA" – Travel Health Brief *(incorporating all information and advice listed above)*					

TRAVEL RISK ASSESSMENT - MANAGEMENT & IMMUNISATION CONSENT FORM

At least 4 hours prior to attending your consultation, complete pages 1, 2 and 4 and email a scanned copy of the form to medsuite@lloyds.com. Please submit the original on appointment.

BLOSSOMS HEALTHCARE

GP SERVICES • HEALTH ASSESSMENT • OCCUPATIONAL HEALTH

Vaccination Screening Questions

It is important to answer all questions below 'In Confidence'!		YES	NO
1.	Are you sick today? Specify:	☐	☐
2.	Does having an injection make you feel faint (Needle Phobia)?	☐	☐
3.	Have you received any 'LIVE' Vaccines (BCG, MMR, Chicken Pox, Yellow Fever), in the past 3 weeks?	☐	☐
4.	During the last 3 months have you received a transfusion of Blood or Blood Products, or been given a medicine called 'Immune Gamma Globulin'?	☐	☐
5.	Is your immune system compromised because of a disease or treatment? [*Examples of this are: Cancer, Leukaemia, HIV/AIDS, current or recent treatment (within 6 months) chemotherapy or radiotherapy, high doses of steroids or anti-cancer drugs that affect the immune system, recent organ or bone marrow transplant*].	☐	☐
6.	Is your immune system suppressed because of HIV infection? [*Rarely, people who are HIV positive but are fit and well, are receiving highly active anti-retroviral therapy and have high CD4 count may receive vaccination*].	☐	☐
7.	Do you have a disorder of the "Thymus Gland" such as Myasthenia Gravis, Thymoma, or history of Thymus removal or radiation?	☐	☐
8.	Do you or any close family member have epilepsy?	☐	☐
9.	Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?	☐	☐
10.	**Women only:** Are you breastfeeding, or are you pregnant, or is there a chance you would become pregnant in the next 3 months? *[Under unusual circumstances, pregnant women may be vaccinated if they are travelling to a destination at a high risk for Yellow Fever. Pregnant women must carefully consider if a trip to these destinations is wise, as there are diseases in addition to YF, such as malaria, that will be a threat to their health and that of the unborn baby].*	☐	☐

Traveller's Consent

- I acknowledge that inoculations / vaccinations provided by Blossoms Healthcare is a **CHARGEABLE SERVICE** and that payment (credit/debit card) details will be taken on the day of appointment.
- The information completed by me on this form is true and correct to the best of my knowledge.
- I have received information on the risks and benefits of the inoculations(s) recommended and had the opportunity to ask questions.
- I consent to receiving the agreed vaccinations and prophylaxis against Malaria and other diseases, as recommended.
- I acknowledge that as part of the vaccination process and as a precaution; I am requested and expected to wait for at least 15 minutes after the vaccine administration, before leaving the clinic.

Traveller's Signature		Date	/ / 20
Clinician's Signature		Date	/ / 20