Travel Health Risk Assessment Form

Please complete page 1 & 2 prior to your travel appointment and bring all 3 pages to the Travel Nurse.

Personal details

Name:

Date of Birth: Male [ ] Female [ ]

Easiest contact telephone number:

E.mail:

GP name and address if not enrolled at this medical practice:

Date of Departure…… **Overall length of trip……..**

Itinerary and purpose of visit

Country to be visited	Length of stay	Away from medical help at destination? If so, how remote? Urban or Rural?
1.		
2.		
3.		
4.		
5.		
6.		

Please circle the descriptions that best describe your trip

1.	*Type of trip*	Business	Pleasure	Other
2.	*Holiday type*	Package	Self-organised	Backpacking
		Camping	Cruise ship	Trekking
3.	*Accommodation*	Hotel	Relatives/family home	Other……...
4.	*Travelling*	Alone	With family/friend	In a group
5.	*Staying in area which is*	Urban	Rural	Altitude
6.	*Planned activities*	Safari	Adventure	Other

Personal medical history

Do you have any recent or past medical history of note? This includes diabetes, heart or lung conditions, thymus disorder.

List any current or repeat medications.

Do you have any allergies, for example to eggs, antibiotics, nuts?

Patient Name: **Date of Birth:**

Have you ever had a serious reaction to a vaccine given to you before?

Does having an injection make 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 pregnancy or breast feeding?

Have you taken out travel insurance? If you have a medical condition, have you informed the insurance company about this?

Please give any further information that may be relevant, including any future travel plans.

Vaccination history

Have you ever had any of the following vaccinations/malaria tablets, and if so, when?

Tetanus/Diptheria	☐	Polio	☐	MMR	☐
Typhoid	☐	Hepatitis A	☐	Hepatitis B	☐
Meningitis	☐	Yellow Fever	☐	Influenza	☐
Rabies	☐	Jap B Enceph	☐		

Other

Malaria tablets

For discussion when risk assessment is performed within your appointment:

I 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.

Signed: Date:

For official use

Patient name: Authorising Doctor……

Travel risk assessment performed Yes [ ] No [ ] Authorisation for Nurse to administer vaccination.

Signed……..

Travel vaccines recommended for this trip

Disease protection	Recommended	Further information
Hepatitis A		
Hepatitis B		
Typhoid		
Cholera		
Tetanus/Diptheria		
MMR		
Polio		
Meningitis ACWY		
Yellow Fever		
Rabies		
Japanese B Encephalitis		

Other **Travel Record card supplied** ☐

Travel advice and/or leaflets given as per travel protocol

Food, water and personal hygiene advice ☐ Travellers diarrhoea ☐ Hepatitis B, C and HIV ☐

Insect bite prevention ☐ Rabies ☐ Accidents ☐ Insurance ☐ Air travel ☐

Sun and heat protection ☐ Hajj travel ☐ Yellow Fever ☐ Blood borne virus ☐

Global Traveller Checklist ☐ Malaria ☐ Altitude sickness ☐ Cruise ship travel ☐

Other ☐

Malaria prevention advice and malaria chemoprophylaxis

Atovaquone + proguanil (Malarone) ☐ Chloroquine ☐ Mefloquine ☐ Doxycycline ☐

Further information
e.g. weight of child

Signed by: Position: Nurse Date: