**Beechwood Surgery**

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| **Personal details** | |
| Name: | Date of birth:  Male [ ] Female [ ] |
| Easiest contact telephone number | |
| Email | |

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| --- | --- | --- |
| **Dates of trip** | | |
| Date of departure | | |
| Return date or 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? |
| 1. |  |  |
| 2. |  |  |
| Future travel plans |  |  |
|  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Please tick as appropriate below to best describe your trip** | | | | | | |
| 1.Type of trip | Business |  | Pleasure |  | Other |  |
| 2.Holiday type | Package |  | Self organised |  | Backpacking |  |
| Camping |  | Cruise ship |  | Trekking |  |
| 3.Accomodation | 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 |  |

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| **Personal Medical History** |
| Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions?) |
| List of any current or repeat medications |
| Do you have any allergies for example to eggs, antibiotics, nuts? |
| 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 and if you have a medical condition, informed the insurance company about this? |
| Please write below any further information which may be relevant: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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. 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**

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| **FOR OFFICIAL USE** | | | |
| Patient Name : | | | |
| Travel Risk Assessment Performed Yes [ ] No [ ] | | | |
| 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 |  |  |  |
| Other |  |  |  |

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| **Travel advice and leaflets given as per travel protocol** | | | | | |
| Food water and personal hygiene |  | Travellers’ diarrhoea |  | Hepatitis B and HIV |  |
| Insect bite prevention |  | Animal bites |  | Accidents |  |
| Insurance |  | Air travel |  | Sun and heat protection |  |
| Websites | | Travel Record card supplied | | |  |
| Other | | |  |

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| **Malaria prevention advice and malaria chemoprophylaxis** | | | |
| Chloroquine and proguanil |  | Atovaquone and proguanil (Malarone) |  |
| Chloroquine |  | Mefloquine |  |
| Doxycycline |  | Malaria advice leaflet given |  |

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| Further information |
| e.g. weight of child |

**Signed by: Position: Date: .**

Now scan this form into the patient’s record on the computer for evidence of best practice.