

Measham Medical Unit

TRAVEL RISK ASSESSMENT FORM

Personal details						
Name:			Date of birth:		Age:	
			Male []		Female []	
Telephone: Home		Work		Mobile		
E mail						
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.						
3.						
Please tick as appropriate below to best describe your trip						
1. Holiday type	Business	<input type="checkbox"/>	Volunteer/Aid Worker	<input type="checkbox"/>	Trekking	<input type="checkbox"/>
	Package	<input type="checkbox"/>	Self organised	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>
	Camping	<input type="checkbox"/>	Cruise ship	<input type="checkbox"/>	Other	<input type="checkbox"/>
Accommodation	Hotel	<input type="checkbox"/>	Relatives / Friends	<input type="checkbox"/>	Other	<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Staying in area which is	Urban	<input type="checkbox"/>	Rural	<input type="checkbox"/>	Altitude	<input type="checkbox"/>
Planned activities	Safari	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Other	<input type="checkbox"/>

Personal medical history
Do you have any recent/past medical history of note? (Including diabetes, heart or lung conditions, HIV, thymus disorders, Crohn's disease or psoriasis)
List any current/repeat or OTC 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? Or to antimalarials – if so which ones?
Have you received any of the following in the last 3 weeks? Polio BCG Yellow Fever
Do you or any close family members have epilepsy?
Do you have any history or mental illness including depression or anxiety
Have you recently undergone radiotherapy, chemotherapy, steroid treatment or had your spleen removed?
<i>Women only:</i> Are you pregnant or planning pregnancy or breast feeding?
Please write below any further information which you feel 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 _____

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			

TRAVEL ADVICE AND LEAFLETS GIVEN

Food water and personal hygiene advice	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	

MALARIA PREVENTION ADVICE and MALARIA CHEMOPROPHYLAXIS

Chloroquine and proguanil	Atovaquone + proguanil (Malarone)
Chloroquine	Mefloquine
Doxycycline	Malaria advice leaflet given

FUTHER 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