CATHAYS SURGERY

TRAVEL HEALTH RISK ASSESSMENT

Please complete this form at least 6 weeks prior to travel health appointment for the Practice Nurse can assess your travel health needs.
Please note we are unable to conduct the consultation without this document.
For non-NHS vaccines there will be a charge for the vaccine cost.

Surname	Forename
Date of Birth	Male/Female
Easiest contact number:	E-mail:

Date of departure:
Return date of overall trip:
Countries you intend to visit? (including stopovers)

Please circle the descriptions that best describe your trip

1.	Type of Trip	Business	Pleasure	Other: please specify
2.	Holiday Type	Package Camping	Self-organised Cruise Ship	Backpacking Trekking
3.	Accommodation	Hotel Hostel	Relatives/Family Home	Other: please specify
4.	Travelling	Alone	With family/friend	In a group
5.	Staying in an area which is	urban	Rural	Altitude
6.	Planned activities	Safari	Adventure	Other: Please specify

Will you be travelling to a location where medical help is non-existent (even for a short period of time)? YES/NO
If YES please give details

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MEDICAL HISTORY

1.	Do you have any recent or past medical history of note? This includes diabetes/heart or lung conditions/thymus disorders etc.?YES/NO If YES, please specify:
2.	Do you have any Allergies, in particular to egg/ antibiotics? YES/NO If YES please specify:
3.	Are you pregnant, breast feeding or planning pregnancy?
4.	List any medications, including over the counter medications:
5.	Have you ever had a serious reaction to a vaccine given to you before? YES/NO If YES, what was the reaction?
6.	Does having an injection make you feel faint?
7.	Do you or a close member of your family have epilepsy?
8.	Do you have any history of mental illness including depression or anxiety?
9.	Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
10.	Please give any further information that may be relevant, including any future travel plans.

VACCINATION HISTORY

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

Please tick the relevant boxes, and date vaccination given.

	Tick	Date		Tick	Date		Tick	Date
Tetanus			Polio			Diptheria		
Typhoid			Hepatitis A			Hepatitis B		
Meningitis C			Yellow Fever			Influenza		
Meningitis ACWY			Jap B encephalitis			Swine Flu		
Rabies			Tick Borne encephilitis					
Other: please specify								

All the above for discussion when risk assessment is performed during 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/TO BE PUT FOR SIGNING BY GP ONCE COMPLETED BY PN/THEN RETURNED TO PN TRAY.

PATIENT SPECIFIC DIRECTION

Patient Name: **Patient Date of Birth:**

Travel vaccination identified and recommended for this trip:

Disease protection	Yes please tick	Date given	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Tetanus/Diptheria/Polio			
Meningitis acwy			
Rabies			
Yellow fever			
Japanese encephalitis			
Tick borne encephalitis			
Swine Flu			
Other: please specify			

Travel advice and leaflets given as per travel protocol: please circle

Food/water/hygiene advice	Traveller's diarrhoea	Hepatitis B/C HIV	Insect bite avoidance	Animal bites
Accidents	Air travel	Sun/heat protection	Hajji Travel	Travel insurance
Travel record supplied	Websites	Referred to yellow fever centre	Post travel advice given	other

Malaria prevention advice and malaria prophylaxis recommended

Choloquine and proguanil	Atovaquone and proguanil (malarone)
Chloroquine	Mefloquine (checklist)
Doxycycline	Malria advice leaflet

Further information:
E.g.: Weight of child

Signed (Patient) Date:

Signed (Doctor) Date

Signed (Practice Nurse) Date