Shaftesbury Medical Centre

Travel Questionnaire

(Patient Specific Direction)

Form to be completed prior to Travel appointment with Practice Nurse. Please either drop in to the surgery or email it to shaftesburymedical.centre@nhs.net

Date form completed:

PATIENT DETAILS

Patient Name:

Date of Birth:

EMIS No:

Contact Number:

TRAVEL DETAILS

Country	Start Date	Return Date	Accomodation (hotel/relative/camping)	Urban/Rural
1.				
2.				
3.				

TRAVEL VACCINES RECOMMENDED

1. Hepatitis A YES/NO
2. Hepatitis B YES/NO
3. Typhoid YES/NO
4. Diptheria/Tetanus/Polio (DT/P) Revaxis YES/NO
5. Meningitis ACWY/Nimenrix YES/NO
6. Rabies YES/NO
7. Cholera YES/NO
8. Japenese B Encephalitis YES/NO

9. Yellow Fever YES/NO
10. Tick Bourne Encephalitis YES/NO
11. Other YES/NO

MALARIA PREVENTION and CHEMOPROPHYLAXIS

1. Chloroquine YES/NO
2. Mefloquine eg Lariam YES/NO
3. Primaquine YES/NO
4. Proguanil YES/NO
5. Proguanil with Atovaquine (Malarone) YES/NO
6. Doxycycline YES/NO

OTHER COMMENTS

GP Authorisation Signature: ……..

Date: ……..