**UNIVERSITY MEDICAL GROUP**

**TRAVEL RISK ASSESSMENT FORM**

**To be completed by traveller prior to appointment and emailed or given to reception at surgery.**

Please ensure that you complete as much of this form as possible and that you have fully read the information on our website. This form should be submitted **eight weeks before you travel**.
We only give travel vaccines covered by the **NHS: Hepatitis A, Diptheria, Polio, Typhoid & MMR.**

All other vaccines will need to be obtained from a private travel clinic.
A separate form must be completed for each traveller

| | |
|---|---|
| Name: | Date of birth:<br>Male ☐ Female ☐ |
| Email: | Telephone number:<br>Mobile number: |
| Preferred method of contact:<br>Email or Telephone | |
| PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW | |
| Date of departure: | Total length of trip: |
| Have you taken out travel insurance for this trip? | |

| COUNTRY TO BE VISITED | CITY OR RURAL | LENGTH OF STAY |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY

| | | |
|---|---|---|
| ☐ Holiday | ☐ Staying in hotel | ☐ Backpacking |
| ☐ Business trip | ☐ Cruise ship trip | ☐ Camping |
| ☐ Expatriate | ☐ Safari | ☐ Adventure |
| ☐ Volunteer work | ☐ Pilgrimage | ☐ Diving |
| ☐ Healthcare worker | ☐ Medical tourism | ☐ Visiting friends/family |

Additional information

| PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY | | | |
|---|---|---|---|
| | Yes | No | Details |
| Are you fit and well | ☐ | ☐ | |
| Any allergies including food, latex, medication | ☐ | ☐ | |
| Severe reaction to a vaccine before | ☐ | ☐ | |
| Tendency to faint with injections | ☐ | ☐ | |
| Recent chemotherapy/radiotherapy/organ transplant | ☐ | ☐ | |
| HIV/AIDS | ☐ | ☐ | |
| Immune system condition | ☐ | ☐ | |
| | Yes | No | Details |
| Women only | ☐ | ☐ | |
| Are you pregnant? | ☐ | ☐ | |
| Are you breast feeding? | ☐ | ☐ | |
| Are you planning pregnancy while away? | ☐ | ☐ | |

| Please list any medication that you are taking other than what is prescribed at this practice eg: purchased over the counter |
|---|
| |

| PLEASE SUPPLY INFORMATION ON ANY VACCINES YOU HAVE HAD IN THE PAST | | | | |
|---|---|---|---|---|
| Tetanus/polio/diphtheria | ☐ Date: | | Typhoid | ☐ Date: |
| Hepatitis A | ☐ Date: | | Pneumococcal | ☐ Date: |
| MMR | ☐ | | | |

| Any additional information of other vaccines received: |
|---|
| |

| Staff Use Only – 2 week turn around | | Please Initial |
|---|---|---|
| Date Received by reception | | |
| Date given to clinical coders with MRE | | |
| Date passed to nurse from coders | | |