Pre-Travel Health Planner

(Please complete one form per traveller)

THIS FORM NEEDS TO BE COMPLETED AND RETURNED BEFORE YOUR APPOINTMENT

Please complete and hand in this form when you book your appointment. Your appointment needs to be made for 8 weeks or more before you travel.

Todays Date			Your Doct					Appointme Date	ent			
Name					Address							
Date of Birth	1			ohone ber				Departure	Date			
Allergies					Regular Medication							
Medical History	1											
Destination List all areas you are visiting in							Duration List the duration of each area and stop over					
	TYPE	OF VISIT	- Ple	ase ti	ck ALL options	that	apply	for your ty	pe of	· Visit		
Staying at a Tourist Resort		Staying in a Hotel			Visiting Friends or Relatives		Staying at an Inland Area			Staying at a Coastal Area		
On Board a Ship		Back Packing			Trekking		Jungle or Bush Exploration			Other		
										QUE OR CASH AT QUIRED FOR YOUR		
THE	E BEL	OW SECT	ION I	S TO	BE COMPLETE	D BY	THE	TRAVEL C	LINIC	NURSE.		
Recommended Immunisation			$\sqrt{}$		Past Immunisations			Needs	Given Today			
Diptheria											,	
Polio												
Tetanus Typhoid												
Hepatitis A												
Yellow Fever												
Hepatitis B												
Influenza												
Jap B Enchephalatis												
Tick Borne Enchep												
Pneumococcal Rabies												
Malaria Check				Recommendation:								
Literature Advice				Non-Imms Advice				Booster Information				