COLINTON SURGERY TRAVEL ASSESSMENT FORM

PLEASE BE AWARE THERE IS A CHARGE FOR SOME OF THE VACCINES.
THIS CHARGE MUST BE PAID IN FULL AT TIME OF FIRST VACCINATION

NAME: **Date of birth:**

Date travel begins:

Length of trip (in days):

ITINERARY AND PURPOSE OF VISIT

Countries to be visited	Length of stay	Away from medical help at destination, if so how remote?
1		
2		
3		
4		
5		

PLEASE TICK BELOW TO BEST DESCRIBE YOUR TRIP

1. Type of trip	Business	☐	Pleasure	☐	Other	☐
2. Holiday type	Package	☐	Self Organised	☐	Backpacking	☐
	Camping	☐	Cruise Ship	☐	Trekking	☐
3. Accommodation	Hotel	☐	Relatives/Family home	☐	Other	☐
4. Travelling	Alone	☐	With family/Friend	☐	In a group	☐
5. Staying in area which is	Urban	☐	Rural	☐	Altitude	☐
6. Planned activities	Safari	☐	Adventure	☐	Other	☐

PERSONAL MEDICAL HISTORY

Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions

List all medication you take:

Do you have any allergies? (e.g. eggs, antibiotics, nuts or latex)
Have you ever had a serious reaction to a vaccination?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
Women only: Are you pregnant or planning pregnancy or breastfeeding?
Please write below any further information which may be relevant:

For discussion when risk assessment is performed within your appointment:

I am **not** pregnant. I have received information on the risks and benefits of the vaccinations recommended and have had the opportunity to ask questions. I consent to the vaccinations being given.
I have been advised to view the Fit to Travel website.
Malaria. (Discussed if relevant) I have been briefed on signs & symptoms, bite prevention, chemo-prophylaxis, insect bites and worsening statements.
I am aware there may be a charge for supply and administration of travel vaccinations and consent to pay in full the agreed sum as soon as requested.

Signed: Date:

PLEASE SEE OVER FOR COST OF VACCINATIONS

IMPORTANT - PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT OR WE MAY NOT BE ABLE TO COMPLETE THE CONSULTATION

NAME: **Date of birth:**

Tel No.

N.B. PAYMENT FOR FULL COURSE OF IMMUNISATIONS IS REQUIRED AT THE TIME OF *FIRST* VACCINATION

SUBSEQUENT VACCINATIONS WILL NOT BE GIVEN UNTIL FULL PAYMENT IS MADE

TRAVEL VACCINATIONS RECOMMENDED FOR THIS TRIP *

*(*completed by nursing staff at travel clinic appointment)*

	Required				
	Yes	No	Patient declined	Cost for full course	Total cost
Tetanus, polio, diphtheria (NHS) 1 vaccine					
Typhoid (NHS)					
Hepatitis A (NHS)					
Disease protection advice given					
Hepatitis B (Private) (3 vaccines @£30 each)				£ 90	
plus booster at a year				£ 30	
Meningitis Menveo (Private) 1 vaccine only				£ 60	
Yellow Fever (Private) 1 vaccine only				£ 65	
Rabies (Private) (3 vaccines @ £65 each)				£ 195	
Jap B Encephalitis (Private) (2 vaccines @ £100 each)				£ 200	
Prescription for anti-malarials				£ 10	
Other					
TOTAL FEE (payment in full is required at the time of first vaccination)					

To be completed by reception staff

AMOUNT PAID

DATE PAID

PAYMENT TAKEN BY

PASS COMPLETED FORM TO MAUREEN LISTER FOR CODING

Schedule of Vaccinations

to be completed by nursing staff at your appointment

NAME: **Date of birth:**

	Day 0	Day 7	Day 14	Day 21	Day 28	Day 56
Tet / Polio /Diptheria						
Hep A						
Typhoid						
Hep B						
Hep A + Typhoid						
Hep A + Hep B						
Rabies						
Meningitis						
Yellow Fever						
Other						

PATIENT NAME.....

COLINTON SURGERY VACCINE SCHEDULE FORM

	Day 0	Day 7	Day 14	Day 21	Day 28	Day 56
Tet/Polio/Diptheria						
Hep A						
Typhoid						
Hep B						
Hep A + Typhoid						
Hep A + Hep B						
Rabies						
Meningitis Menveo						
Yellow Fever						
Jap B						

AUTHORISATION FOR PATIENT SPECIFIC DIRECTION

Rabies x 3		Jap B X 2		Yellow Fever x1		Vivotif		Revaxis		Menveo	

Assessor's Name : _____ Signature: _____ Date

Prescriber's Name : _____ Signature: _____ Date