**Elbury Moor Medical Centre**

**Partners:**

**Dr Ruth Taylor**

**Dr Dibya Mahanta**

**Dr Helen Rutter**

**Dr Dietlind Elsner**

**Dr Katie Robinson**

**Dr Amy Willetts**

**Practice Manager:**

**Jo Walker**

**Travel Risk Assessment Form**

***APPOINTMENT DATE NURSE (INITIAL)***

Please complete this form prior to your travel appointment and return to reception

**Please ensure you sign and date this form overleaf**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Personal Details | | | | |
| **Name:** | | | | **Date of birth:**  Male [ ] Female [ ] Other [ ] |
| Contact Telephone Number: | | | | |
| **E mail:** | | | | |
| Date of Departure: | | | **Return Date:** | |
| **Itinerary and purpose of the trip (use extra paper if required)** | | | | |
| **Country to be visited** | **Length of stay** | Is medical help available at destination? | | |
| **1.** |  |  | | |
| **2.** |  |  | | |
| **3.** |  |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Please tick as appropriate 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 |  | 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 any current or repeat medications |
| Do you have any allergies for example to eggs, antibiotics, nuts? If yes please list them. |
| Have you ever had a serious reaction to a vaccine given to you before? |
| Does having an injection make you feel faint? |
| Do you or any close family members have epilepsy? |
| Do you have any history or mental illness including depression or anxiety? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |
| ***Women only:* Are you pregnant or planning pregnancy or breast-feeding?** |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this? |
| Please write below any further information which may be relevant. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Vaccination History | | | | | |
| Have you ever had any of the following vaccinations/malaria tablets and if so when? | | | | | |
| Tetanus |  | Polio |  | Diphtheria |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | Tick Borne |  |
| Other |  | | | | |
| Malaria tablets |  | | | | |

For discussion when risk assessment is performed within 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NB: Please note that some vaccines are chargeable and payment will be required before these are ordered into the Surgery on your behalf.**