TRAVEL RISK ASSESSMENT FORM-
To be completed 8 weeks prior to travelling

Name:		Date of Birth	
		Male:	Female:
Email:		Home Number:	Mobile Number:

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP, PLEASE FILL IN THE SECTION BELOW:

Date of Departure:		Total Length of Trip:	
Country To Be Visited	Exact Location Or Region	City or Rural	Length Of Stay
1.			
2.			
3.			
Have you taken out travel Insurance for this trip?		Do you plan to travel abroad again in the future?	

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

	Holiday		Healthcare Worker		Backpacking		Visiting Friends and Family.
	Business Trip		Staying in a hotel		Camping/hostels	Additional information:	
	Expatriate		Cruise ship trip		Adventure		
	Volunteer Work		Pilgrimage		Diving		

PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY

	Yes	No	Details
Any allergies including food, latex, medication?			
Severe reaction to a vaccine before?			
Tendency to faint with injections?			
Any surgical operations in the past, including e.g. your spleen or thymus gland removed?			
Recent chemotherapy/ radiotherapy/ organ transplant?			
Anaemia?			

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	Yes	No	Details
Bleeding/ Clotting disorders (including history of DVT)?			
Heart disease (e.g. angina, high blood pressure)?			
Diabetes?			
Disability?			
Epilepsy/seizures?			
Gastrointestinal (stomach) complaints?			
Liver and or kidney problems?			
HIV/AIDS?			
Immune system condition?			
Mental health issues (including anxiety, depression)?			
Neurological (nervous system) illness?			
Respiratory (lung) disease?			
Rheumatology (joint) conditions?			
Spleen problems?			
Any other conditions?			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			
Have you undergone FGM / been cut / circumcised?			

ARE YOU CURRENTLY TAKING ANY MEDICATION?

PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST

	Tetanus/ Polio/ Diphtheria		Rabies		Hepatitis A		Influenza
	Typhoid		Yellow Fever		Hepatitis B		Pneumococcal
	Cholera		MMR		Japanese Encephalitis		Meningitis
	Tick Borne Encephalitis		BCG		Malaria	Other:	

Any Additional Information:

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Patient Name:	Date of Birth:	Travel risk assessment Performed? YES/NO

TRAVEL VACCINES RECOMMENDED FOR THIS TRIP:

Disease Protection	Yes	No	Patient declined Vaccine	Vaccine name, dose & schedule for PSD
Hepatitis A				
Hepatitis B				
Typhoid				
Cholera				
Tetanus				
Diphtheria				
Polio				
Meningitis (ACWY)				
Yellow Fever				
Rabies				
Japanese B Encephalitis				
Other				

TRAVEL ADVICE AND LEAFLETS GIVEN AS PER TRAVEL PROTOCOL:

	Food, Water and Personal hygiene advice.		Insect Bite Prevention		Insurance		Websites
	Travel record card Supplied		Travellers' Diarrhoea		Animal Bites		Air Travel
	Blood and bodily fluid infection risk e.g. Hep B		Accidents		Sun and heat protection	Other:	

MALARIA PREVENTION ADVICE AND MALARIA CHEMOPROPHYLAXIS:

	Chloroquine and Proguanil		Chloroquine		Doxycycline
	Atovaquone & Proguanil		Mefloquine		Malaria advice leaflet given

FURTHER INFORMATION:

AUTHORISATION FOR PATIENT SPECIFIC DIRECTION (PSD) USE:

Name:	Signature:	Date:

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