



PRE-ASSESSMENT FORM FOR TRAVEL CLINIC

To be returned at least 2 working days prior to appointment with nurse.

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

Personal Details

Name:

Date of birth:

Male [] Female []

Contact telephone number:

Email:

GP name and address (if not registered at this surgery):

Dates of trip

Departure:

Return (or length of trip):

Itinerary and purpose of visit

Country to be visited

Length of stay

Away from medical help at destination?
If yes, how remote?

1.

2.

3.

Please circle the descriptions that 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 an area which is | Urban | Rural | Altitude |
| 6. Planned activities | Safari | Adventure | Other |



Personal medical history (please supply printout from own GP)

Do you have any recent or past medical history of note? This includes diabetes, heart or lung conditions, thymus disorder

List any current or repeat medications

Do you have any allergies, for example to eggs, antibiotics, nuts, etc.?

Have you ever had a serious reaction to a vaccine given to you before?

Do you or any close family members have epilepsy?

Do you have any history of 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?

Please give any further information that may be relevant, including any future travel plans:



Vaccination history

Have you ever had any of the following vaccinations/medication previously for travel? If so, when approximately?

Vaccination	Date
Hepatitis A	
<hr/>	
Hepatitis A Booster	
<hr/>	
Hepatitis B:	1
	2
	3
<hr/>	
Japanese Encephalitis	1
	2
<hr/>	
Malaria tablets	
<hr/>	
Meningitis	
<hr/>	
Rabies	1
	2
	3
<hr/>	
Tick borne encephalitis	1
	2
	3
<hr/>	
Typhoid	
<hr/>	
Yellow Fever	
<hr/>	
Yellow Fever Booster	
<hr/>	
Childhood vaccinations, e.g. Tetanus	
<hr/>	
	Diphtheria
<hr/>	
	Polio
<hr/>	
Any other vaccinations, e.g.	Influenza
	Swine flu



FOR OFFICIAL USE

Patient name:

Travel risk assessment performed: yes/no

Travel vaccines recommended for this trip:

Disease protection Yes/No/Further Information

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

Malaria prevention advice and malaria chemoprophylaxis

Food, water and personal hygiene advice/ Travellers' diarrhoea/ Hepatitis B, C and HIV

Insect bite prevention/ animal bites/ accidents/ Insurance/ Air travel/ Sun and heat protection/ Hajj travel/ Travel record supplied

Websites

Other

Chloroquine and proguanil/ Atovaquone & proguanil (Malarone)/ Chloroquine/ Mefloquine/

Doxycycline/ Malaria advice leaflet given

Further information

Nurses Signature:

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 have been advised that I will be charged a fee for these vaccinations – see annex for charges. I have been made aware that some of these vaccines may be available free from my own GP, however I have chosen to be treated privately. I consent to the vaccines being given.

Signed:..... Date:.....