# G:\Corporate Stationery\Logo\SmallLogo.jpg

# TRAVEL RISK ASSESSMENT FORM

# An appointment with the Nurse should be made at least 6 weeks prior to travelling.

Please complete this form and bring it to your travel appointment. Please be advised that should you attend without a completed Travel Risk Assessment form you will be asked to rebook for another time.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal details** | | | | | | | | | |
| **Name:** | | | | | **Date of birth:** | | | | |
| **Travel Vaccination**  **Appointment booked: Date** | | | | | **Time** | | | | |
| **Easiest contact telephone number** | | | | | | | | | |
| **E mail** | | | | | | | | | |
| **Dates of trip** | | | | | | | | | |
| **Date of Departure** | | | | | | | | | |
| **Return date or overall length of trip** | | | | | | | | | |
| **Itinerary and purpose of visit** | | | | | | | | | |
| **Country to be visited** | | **Length of stay** | | | | **Away from medical help at destination, if so, how remote?** | | | |
| **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 | |  | 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, thymus disorder) | | | | | | | | | |
| List any current or repeat medications | | | | | | | | | |
| Do you have any allergies for example to eggs, antibiotics, nuts? | | | | | | | | | |
| 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 his? | | | | | | | | | |
| 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 |  |
| Covid vaccine | 1st 2nd 3rd | | | | |
| 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: | | | | | |

|  |
| --- |
| **For official use only**  **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 |  |  |  | | Covid |  |  |  | | Other |  |  |  | |
| **TRAVEL ADVICE AND LEAFLETS GIVEN AS PER TRAVEL PROTOCOL**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Food water and personal hygiene advice |  | Travellers’ diarrhoea |  | Hepatitis B and HIV |  | | Insect bite prevention |  | Animal bites |  | Accidents |  | | Insurance |  | Air travel |  | Sun and heat protection |  | | Websites |  | Travel Record card supplied  OTHER | | | | |
| MALARIA PREVENTION ADVICE and MALARIA CHEMOPROPHYLAXIS   |  |  |  |  | | --- | --- | --- | --- | | Chloroquine and proguanil |  | Atovaquone + proguanil (Malarone) |  | | Chloroquine |  | Mefloquine |  | | Doxycycline |  | Malaria advice leaflet given |  |   **FUTHER INFORMATION**  e.g. weight of child  **Signed by: Position: Date:**  Completed forms MUST be scanned to patients records |

**Review Information and associated documents**

|  |  |
| --- | --- |
| **Document Location** | Team Net |
| **Policy Review Date** | August 2022 |
| **Clinical Lead Reviewer** | Director of Nursing |
| **Administrative Lead Reviewer** | Balvinder Devi |

**Review Updates**

|  |  |
| --- | --- |
| **V1.0** | Created |
| **V2.0** | Reviewed August 21. Form redesigned, additional questions added |
|  |  |
|  |  |