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# 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.

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| **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 |

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| **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: |

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| **For official use only****Patient Name:**  |
| Travel risk assessment performed Yes 🞏 No 🞏  |
| **TRAVEL VACCINES RECOMMENDED FOR THIS TRIP**  |
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|  |  |  |  |
| --- | --- | --- | --- |
| 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 |  |  |  |

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| **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 suppliedOTHER |

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| 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**

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

**Review Updates**

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