

Travel Risk Assessment Form

Please complete this form prior to your travel appointment and return to reception before your appointment date (or it may be completed as a booked telephone consultation)

Name:	Date of birth:
Easiest contact telephone number:	Male Female
Approximate date of departure	Overall length of trip

Itinerary and details of visit:

Country visiting	Length of stay	How remote/away from medical help
1		
2		
3		

Please tick as appropriate below to best describe your trip

Type of trip:	Business	Pleasure	Other:
Holiday type:	Package	Backpacking	Self organised
	Cruise	Camping	Trekking
Travelling:	With family/friend	Alone	In a group
Accommodation:	Urban	Rural	Altitude
Planned Activities:	Safari	Adventure	Other:

Children only: Weight

You may like to consider accessing travel information on internet sites or, if unable to, the Public Library can assist in internet searches

National Travel Health Network and Centre
 Department of Health
 UK Foreign Office
 Fit For Travel

www.NaTHNaC.org
Health advice for travellers
www.fco.gov.uk
www.fitfortravel.sco.nhs.uk

Personal Medical History

Do you have any allergies, for example eggs, antibiotics, nuts, latex?

Do you have any recent or past medical problems (including diabetes, heart or lung conditions, DVT?)

Give current or repeat medications

Have you ever had a reaction to a vaccine? Please give details.

Do you have any history of mental illness including depression or anxiety?

Have you taken out travel insurance and included any medical condition you have?

Women only: Are you pregnant, breastfeeding or planning a pregnancy?

Please write any further information which may be relevant.

Vaccination history

Have you ever had any of the following vaccinations/malaria tablets? If so, when?

Tetanus	Polio	Diphtheria
Typhoid	Hepatitis A	Hepatitis B
Rabies	Yellow Fever	Influenza
Meningitis	Tick Borne	Japanese B Encephalitis
MMR	Other	Malaria Tablets

For discussion when risk assessment is performed within your appointment

I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I have no reason to think that I might be pregnant. I consent to the vaccines being given.

Signed Date

Print name (if parent giving consent)

For official use

Patient Name

Travel Risk assessment performed

Yes

No

Vaccines recommended for this trip

Disease Protection	Recommended		Further information	Authorised by GP
	Yes	No		
Hepatitis A				
Typhoid				
Hepatitis B				
Diphtheria/Tetanus/Polio				
Rabies				
Meningitis ACWY				
Yellow Fever				
Japanese B Encephalitis				
Cholera				
Other				

Travel advice and leaflets given as per travel protocol

Food / water hygiene

Travellers diarrhoea

Hepatitis B/HIV

Insect bite protection

Rabies / bites

Accidents

Insurance

Air travel

Sun/heat protection

Travel insurance

Travel record card supplied

Malaria prevention and Malaria chemoprophylaxis

Chloroquine and Proguanil

Atovaquone + Proguanil (Malarone)

Chloroquine

Mefloquine

Doxycycline

Malaria advice leaflet given

Signed by: Position Date