**Meddygfa Lansdowne Surgery**

**TRAVEL RISK ASSESSMENT FORM**

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | |  | |
| Name:  Address: | | | | |  | |
| Date of birth: | | | | | Male [ ] Female [ ] | |
| Easiest contact telephone number: | | | | |  | |
| Email: | | | | |  | |
|  | | | | | | |
| **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 circle the descriptions that best describe your trip** | | | | | | |
| 1 Type of trip | Business | | Pleasure | | | Other |
| 2 Holiday type | Packaging | | 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 visits | Safari | | Adventure | | | Other |
| **Personal medical history** | | | | | | |
| Do you have any recent or past medical history of note? This includes diabetes, heart or lung conditions, thymus disorder. | | | | | | |
|  | | | | | | |
|  | | | | | | |
| List any current repeat medications. | | | | | | |
|  | | | | | | |
|  | | | | | | |
| Do you have any allergies for example eggs, antibiotics, nuts? | | | | | | |
|  | | | | | | |
|  | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 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? If you have a medical condition, have you informed the insurance company about this? | | | |
|  | | | |
|  | | | |
| Please give any further information that may be relevant, including any further travel plans. | | | |
|  | | | |
|  | | | |
| **Vaccination history** | | | |
| Have you ever had any of the following vaccination/malaria tablets, and if so when? | | | |
| Tetanus [ ] | Polio [ ] | | Diphtheria [ ] |
| Typhoid [ ] | Hepatitis A [ ] | | Hepatitis B [ ] |
| Meningitis [ ] | Yellow Fever [ ] | | Influenza [ ] |
| Rabies [ ] | Jap B Enceph [ ] | | Tick Bourne [ ] |
| Malaria tablets [ ] | Other: *Please give details* | | |
|  | | | |
| 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: PRACTICE STAFF ONLY** | | | | | |
| **Appointment Date:.....................................Appointment Time........................................** | | | | | |
| 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 Enceph |  | |  | |  |
| Other |  | |  | |  |
| **Vaccines required YES / NO**  **COST FOR PATIENT: £ ......................** | | | | | |
| **Travel advice and leaflets given as per travel protocol**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Food water and personal hygiene advice |  | Travellers’ diarrhoea |  | Hepatitis B, C and HIV |  | Air travel |  | | Insect bite protection |  | Animal bites |  | Accidents |  | Insurance |  | | Sun and heat protection |  | Hajj travel |  | Travel record card supplied |  | Websites |  | | Other : | | | | | | | | | | | | | |
|  | | | | | |
| **Malaria prevention advice and malaria chemoprophylaxis**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Chloroquine and proguanil |  | Mefloquine |  | Atovaquone and proguanil (Malarone) |  | Doxycycline |  | | Malaria leaflet given |  | Chloroquine |  |  | | | | | | | | | |
| Further information | | | | | |
| e.g. weight of child | | | | | |
| Signed by: | | | | | |
| Position: | | | | | |
| Date: | | | | | |