**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. |
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|  |
| List any current repeat medications. |
|  |
|  |
| Do you have any allergies for example eggs, antibiotics, nuts? |
|  |
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| --- |
| 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? |
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|  |
| 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 : |

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|  |
| **Malaria prevention advice and malaria chemoprophylaxis**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Chloroquine and proguanil  |  | Mefloquine |  | Atovaquone and proguanil (Malarone)  |  | Doxycycline |  |
| Malaria leaflet given |  | Chloroquine |  |  |

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| Further information  |
| e.g. weight of child |
| Signed by:  |
| Position: |
| Date: |