

**TALBOT MEDICAL CENTRE
TRAVEL RISK ASSESSMENT FORM**

Please complete this form prior to your travel appointment and return to reception. The Practice Nurse will evaluate the form and will be in touch with you in due course. Please allow 2 weeks for this to be done.

PERSONAL DETAILS:					
NAME:		DATE OF BIRTH:			
		MALE		FEMALE	
CONTACT TELEPHONE NUMBER:					
E-MAIL:					
DATE OF DEPARTURE:			RETURN DATE OR OVERALL LENGTH OF TRIP:		
COUNTRY TO BE VISITED:		LENGTH OF STAY:		AWAY FROM MEDICAL HELP AT DESTINATION? IF SO, HOW REMOTE?	
1.					
2.					
3.					
TYPE OF TRIP:	BUSINESS		PLEASURE		OTHER
HOLIDAY TYPE:	PACKAGE		SELF ORGANISED		BACKPACKING
	CAMPING		CRUISE SHIP		TREKKING
ACCOMMODATION:	HOTEL		RELATIVES/ FAMILY HOME		OTHER
TRAVELING:	ALONE		WITH FAMILY/FRIEND		ALTITUDE
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)
LIST ANY CURRENT OR REPEAT MEDICATIONS:
DO YOU HAVE ANY ALLERGIES TO EGGS, ANTIBIOTICS, NUTS?
HAVE YOU EVER HAD A SERIOUS REACTION TO A VACCINE GIVEN BEFORE? IF SO, WHAT?

DOES HAVING AN INJECTION MAKE YOU FEEL FAINT?
DO YOU OR ANY CLOSE FAMILY MEMBERS HAVE EPILEPSY?
DO YOU HAVE ANY HISTORY OF MENTAL ILLNESS INCLUDING DEPRESSION OR ANXIETY?
HAVE YOU RECENTLY UNDERGONE RADIOTHERAPY, CHEMOTHERAPY OR STEROID TREATMENT?
WOMEN ONLY – ARE YOU PREGNANT, PLANNING PREGNANCY OR BREAST FEEDING?
HAVE YOU TAKEN OUT TRAVEL INSURANCE AND IF YOU HAVE A MEDICAL CONDITION, INFORMED THE INSURANCE COMPANY?
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		JAPANESE ENCEPHALITIS B		TICK BOURNE	
OTHER		MALARIA TALBETS			

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

PATIENT'S NAME:

TRAVEL RISK ASSESSMENT PERFORMED?

YES

NO

SIGNATURE

POSITION DATE:

For completion by travel nurse

Vaccinations advised for travel itinerary as detailed above

Diphtheria/Tetanus/ Polio	Typhoid	Hepatitis A	Hepatitis B	Yellow fever
Meningitis ACWY	Rabies	Japanese encephalitis	Tick-borne encephalitis	Cholera

For completion by doctor

I authorize administration of the above recommended vaccines for travel

Signed

Date