BILLERICAY MEDICAL PRACTICE

TRAVEL RISK ASSESSMENT FORM

Please complete this form and return it to reception as soon as possible, allowing 2-3 working days before your appointment with the travel nurse. Ideally we would like to see you six weeks before your trip.

Personal details	
Name: **Address:** **Postcode:**	**Date of birth:** **Male** [ ] **Female** [ ]
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 (if possible please include town/city, region/area)	**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	

1. Are you suffering from any minor ailments? Yes ☐ No ☐

If yes please give details ………………………………………………………………….……

2. Do you have any long-term medical conditions? Yes ☐ No ☐

If yes please give details ……………………………………………………………………...

3. Do you have a history of epilepsy? . Yes ☐ No ☐

If yes please give details ……………………………………………………………………….

4. Have you ever experienced anxiety, depression or other psychological problems, which have required treatment? Yes ☐ No ☐

If yes please give details ……………………………………………………………………...

5. Have you had your spleen removed? Yes ☐ No ☐

If yes please give details ………………………………………………………………………

6. Have you ever had a bad reaction to a vaccine? Yes ☐ No ☐

If yes please give details ……………………………………………………… ………….

7. Do you have any other allergies, e.g. eggs? Yes ☐ No ☐

If yes please give details ……………………………………………………………………..

8. Are you taking any medication including the oral contraceptive pill, or have you been on antibiotics within the last 10 days? Yes ☐ No ☐

If yes please give details ……………………………………………………………………..

9. Do you smoke? Yes ☐ No ☐
Have you ever smoked? Yes ☐ No ☐
Are you an ex-smoker? Yes ☐ No ☐

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	
Other					
Malaria tablets					

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant and declare this information to be correct. I consent to the vaccines being given after discussion with the practice nurse.
Please be aware that there is a fee for certain vaccinations.

Signed: Date:

For official use

Patient Name:

Travel risk assessment performed?	Yes [ ] No [ ]	By: Date:
Length of Appointment		
Appointment time span (eg: 2 – 3 weeks time)		
Additional comments		

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 Encephalitis			
Malaria Prophylaxis			
Other			

Assessing nurse signature ……...………………………. Date ………………

Prescriber signature …………………………………… Date ………………

Nurse administering vaccine signature ………………… Date ………………