|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | | | | | | | | | | |
| Name | | | | | | | | | | Date of birth  Male [ ] Female [ ] | | | |
| Easiest Contact telephone number  Email | | | | |  | | | | | | | | |
| **Dates of trip** | | | | | | | | | | | | | |
| Date of Departure | | | | |  | | | | | | | | |
| Return Date or overall length of trip | | | | |  | | | | | | | | |
| **Details about Destination** | | | | | | | | | | | | | |
| Country & location to be visited | | | | Length of Stay | | | Away from medical help, if so, how remote? | | | | | | |
| 1. | | | |  | | |  | | | | | | |
| 2. | | | |  | | |  | | | | | | |
| 3. | | | |  | | |  | | | | | | |
| Do you plan to travel abroad again in the future? | | | | | | | | | | | | | |
| **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. Area is | Urban | | | |  | Rural | | | | |  | Altitude |  |
| 6. Planned Activities | Safari | | | |  | Adventure | | | | |  | Other |  |
| **Personal Medical History** | | | | | | | | | | | | | |
| Do you have any recent of past medical history of note? (incl. diabetes, heart or lung conditions) | | | | | | | | | | | | | |
| List any current or repeat medications | | | | | | | | | | | | | |
| Do you have any allergies for example to eggs, antibiotics, nuts or latex? | | | | | | | | | | | | | |
| Have you ever had a serious reaction to a vaccine given to you before? | | | | | | | | | | | | | |
| 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 or planning pregnancy or breastfeeding? | | | | | | | | | | | | | |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this? | | | | | | | | | | | | | |
| Please write below any further information which may be relevant | | | | | | | | | | | | | |
| **Vaccination history** | | | | | | | | | | | | | |
| Have you ever had any of the following vaccinations/malaria 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. 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 Name: | | | | | | | | | | | |
| Travel risk assessment performed Yes [ ] No [ ] | | | | | | | | | | | |
| **Travel Vaccines recommended for this trip** | | | | | | | | | | | |
| Disease protection | Yes | | No | | Patient Declined Vaccine | | | | Vaccine name, dose & schedule for PSD | | |
| Hepatitis A |  | |  | |  | | | |  | | |
| Hepatitis B |  | |  | |  | | | |  | | |
| Typhoid |  | |  | |  | | | |  | | |
| Cholera |  | |  | |  | | | |  | | |
| Tetanus |  | |  | |  | | | |  | | |
| Diphtheria |  | |  | |  | | | |  | | |
| Polio |  | |  | |  | | | |  | | |
| Meningitis ACWY |  | |  | |  | | | |  | | |
| Yellow Fever |  | |  | |  | | | |  | | |
| Rabies |  | |  | |  | | | |  | | |
| Japanese B Encephalitis |  | |  | |  | | | |  | | |
| Other |  | |  | |  | | | |  | | |
| Other |  | |  | |  | | | |  | | |
| **Travel Advice and leaflets given as per travel protocol** | | | | | | | | | | | |
| Food, water and personal hygiene advice | |  | | Travellers’ Diarrhoea | | | |  | Blood and bodily fluid infection risks e.g. Hep B | |  |
| Insect bite prevention | |  | | Animal bites | | | |  | Accidents | |  |
| Insurance | |  | | Air travel | | | |  | Sun and heat protection | |  |
| Websites | |  | | SMS vaccines reminder service set up | | | | | | |  |
| Travel record card supplied | |  | | Other | | | | | | | |
| **Malaria prevention advice and malaria chemoprophylaxis** | | | | | | | | | | | |
| Chloroquine and proguanil | | | | | |  | Atovaquone + proguanil | | | |  |
| Chloroquine | | | | | |  | Mefloquine | | | |  |
| Doxycycline | | | | | |  | Malaria advice leaflet given | | | |  |
| **Further information** | | | | | | | | | | | |
| E.g. weight of child | | | | | | | | | | | |
| **Authorisation for Patient Specific Direction (PSD) Use** | | | | | | | | | | | |
| Name: | | | | | | Signature: | | | | Date: | |