**PATIENTS NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF TRAVEL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ORCHARD MEDICAL PRACTICE**

**Travel risk assessment form**



Please complete this from and return it to our Reception **at least 6 weeks prior to your departure date.** We are unable to offer travel advice less than 6 weeks prior to departure.

The form will be reviewed by a Practice Nurse and you will be contacted with a date and time for your consultation and vaccinations. You may have to attend a private clinic for some vaccinations (the nurse will advise you if this is the case).

Travel clinics are on set days and times and if you are unable to attend these times, you will need to seek advice from a private clinic. Reception can provide you with a copy of your vaccination history upon request.

**Official use only:**

Date form received from Patient:………………..

**TRAVEL RISK ASSESSMENT FORM – Ideally to be completed by traveller prior to appointment**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | Date of birth  Male Female | | | | | | |
| E mail: | | | | Home telephone number:  Mobile number: | | | | | | |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW** | | | | | | | | | | |
| Date of departure: | | | | Total length of trip: | | | | | | |
| **COUNTRY TO BE VISITED** | **EXACT LOCATION OR REGION** | | | **CITY OR RURAL** | | | | | **LENGTH OF STAY** | |
| 1. |  | | |  | | | | |  | |
| 2. |  | | |  | | | | |  | |
| 3. |  | | |  | | | | |  | |
| Have you taken out travel insurance for this trip?  Do you plan to travel abroad again in the future? | | | | | | | | | | |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY** | | | | | | | | | | |
| Holiday      Business trip    Expatriate  Volunteer work    HealthcareWorker | Staying in hotel Backpacking  **Additional Info**  Cruise ship trip Camping/hostels  Safari Adventure  Pilgrimage Diving  Medical tourism Visiting friends/family | | | | | | | | | |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | | | | | | | | |
|  | | | | | | **YES** | **NO** | **Details** | | |
| Are you fit and well today | | | | | |  |  |  | | |
| Any allergies including food, latex, medication | | | | | |  |  |  | | |
| Severe reaction to a vaccine before | | | | | |  |  |  | | |
| Tendency to faint with injections | | | | | |  |  |  | | |
| Any surgical operations in the past, including e.g your spleen or thymus gland removed | | | | | |  |  |  | | |
| Recent chemotherapy/radiotherapy/organ transplant | | | | | |  |  |  | | |
| Anaemia | | | | | |  |  |  | | |
| Bleeding/clotting disorder (including history of DVT) | | | | | |  |  |  | | |
| Heart disease (e.g angina, high blood pressure) | | | | | |  |  |  | | |
| Diabetes | | | | | |  |  |  | | |
| Disability | | | | | |  |  |  | | |
| Epilepsy/seizures | | | | | |  |  |  | | |
| Gastrointestinal (stomach) complaints | | | | | |  |  |  | | |
| Liver and kidney problems | | | | | |  |  |  | | |
| HIV/AIDS/ | | | | | |  |  |  | | |
| Immune system condition | | | | | |  |  |  | | |
|  | | | | | | **YES** | **NO** | **Details** | | |
| Mental health issues (including anxiety/depression) | | | | | |  |  |  | | |
| Neurological (nervous system) illness | | | | | |  |  |  | | |
| Respiratory (lung) disease | | | | | |  |  |  | | |
| Rheumatology (joint) conditions | | | | | |  |  |  | | |
| Spleen problems | | | | | |  |  |  | | |
| Any other conditions | | | | | |  |  |  | | |
| **WOMEN ONLY** | | | | | |  |  |  | | |
| Are you pregnant? | | | | | |  |  |  | | |
| Are you breastfeeding? | | | | | |  |  |  | | |
| Are you planning pregnancy while away? | | | | | |  |  |  | | |
| Have you undergone FGM/been cut/circumcised | | | | | |  |  |  | | |
| **Are you currently taking any medication (including prescribed, purchased, or a contraceptive pill)?** | | | | | | | | | | |
|  | | | | | | | | | | |
| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** | | | | | | | | | | |
| Tetanus/polio/diphtheria | |  | MMR | |  | | Influenza | | |  |
| Typhoid | |  | Hepatitis A | |  | | Pneumococcal | | |  |
| Cholera | |  | Hepatitis B | |  | | Meningitis | | |  |
| Rabies | |  | Japanese Encephalitis | |  | | Tick Borne Encephalitis | | |  |
| Yellow fever | |  | BCG | |  | | Other | | |  |
| Malaria tablets | | | | | | | | | | |
| **Any Additional Information** | | | | | | | | | | |

**HEALTH PROFESSONAL USE ONLY TRAVEL RISK MANAGEMENT FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FOR HEALTH PROFESSIOAL USE ONLY IN CONJUNCTION WITH TRAVEL ASSESMENT FORM** | | | | | |
| **Patient name: dob:**  Childhood immunisation history checked:  Additional information: | | | | | |
| **National database consulted for travel vaccines recommended for this trip and malaria chemoprophylaxis (if required): NaTHNaC: TRAVAX: Other:** | | | | | |
| **Disease protection advised** | **Yes** | **Disease protection advised** | **Yes** | **Malaria Chemoprophylaxis Recommendation** | **Yes** |
| BCG/Mantoux |  | Influenza |  | Atovaquone/proguanil |  |
| Cholera |  | Meningitis ACWY |  | Chloroquine Only |  |
| Dip/Tetanus/polio |  | MMR |  | Chloroquine and proguanil |  |
| Hepatitis A |  | Rabies |  | Doxycycline |  |
| Hepatitis B |  | TBE |  | Mefloquine |  |
| Hepatitis A+B |  | Typhoid |  | Proguanil only |  |
| Hepatitis A + Typhoid |  | Yellow Fever |  | Emergency standby |  |
| Japanese Encephalitis |  | Other |  | Weight of child: |  |

**Previous Vaccine History:**

**Hep A :- 1st 2nd**

**Typhoid :-**

**DTP :-**

**MMR :- 1st 2nd**

Other Vaccines

|  |
| --- |
| **Additional patient management or advice taken following risk assessment – for example**   * Vaccine(s) patient declined following recommendation, and reason why * Telephone NaTHNaC or TRAVAX for advice or used Malaria Reference laboratory fax service * Contacted hospital consultant for specific information in respect of a complex medical condition * Identified specific nature/purpose of VFR travel |

**Authorisation for a Patient Specific Direction (PSD)**

Following the completion of a travel risk assessment, the below named vaccines may be administered under this PSD to:

**Name: dob:**

|  |  |  |
| --- | --- | --- |
| **Name, form & strength of medicine** (generic/brand name as appropriate) | **Dose, Schedule and route of administration** | **Start and finish dates** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Signature of prescriber** | **Date** |
|  |  |

**Travel Risk Assessment Undertaken By:**

|  |  |
| --- | --- |
| **Name** |  |
| **Designation** |  |
| **Signature** |  |
| **Date** |  |

**Please make this patient a min appointment with**

**Before OR min joint appointment**