

**RECTORY MEADOW SURGERY
TRAVEL RISK ASSESSMENT FORM**

| | | | |
|---|--|------------------------|--|
| Patient's Personal Details | | | |
| Full Name: | Date of Birth: | Age: | Male/Female |
| Dates of Trip | | | |
| Date of departure: | Return date (or length of trip): | | |
| Itinerary and Purpose of Visit | | | |
| Country(s) to be visited: | Type of Trip: Business / Pleasure / Other | Accommodation Type: | Away from medical help at destination? If so, how remote? |
| Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)? | | | Yes / No |
| Are you on any regular medication? | | | Yes / No |
| Do you have any allergies, for example to eggs, antibiotics, nuts? | | | Yes / No |
| Have you ever had a serious reaction to a vaccine given to you before? | | | Yes / No |
| Does having an injection make you feel faint? | | | Yes / No |
| Do you or any close family members have epilepsy? | | | Yes / No |
| Do you have any history or mental illness including depression or anxiety? | | | Yes / No |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | | | Yes / No |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this? | | | Yes / No |
| Women only: Are you pregnant or planning pregnancy or breastfeeding? | | | Yes / No |
| Please write below any further information which may be relevant: | | | |

Travel vaccines recommended for this trip (to be completed by Practice Nurse)

| Disease protection | Yes | No | Further information |
|-------------------------|-----|----|---------------------|
| Hepatitis A | | | |
| Hepatitis B | | | |
| Typhoid | | | |
| Cholera | | | |
| Tetanus | | | |
| Diphtheria | | | |
| Polio | | | |
| Meningitis ACWY | | | |
| Yellow Fever | | | |
| Rabies | | | |
| Japanese B Encephalitis | | | |
| Other | | | |

Travel advice and leaflets given as per travel protocol

| | | | | | |
|---|--|------------------------|--|-------------------------|--|
| Food, water and personal hygiene advice | | Travellers' diarrhoea | | Hep B and HIV | |
| Insect bite prevention | | Animal bites | | Accidents | |
| Insurance | | Air travel | | Sun and heat protection | |
| Websites | | Travel record supplied | | Other | |

Malaria prevention advice and malaria chemoprophylaxis

| | | | | | |
|---------------------------|--|----------------------------------|--|------------------------------|--|
| Chloroquine and proguanil | | Atovaquoe + proguanil (Malarone) | | Chloroquine | |
| Mefloquine | | Doxycycline | | Malaria advice leaflet given | |

Further information: eg weight of child

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.

Patient's Signature: _____ Date: _____

For Rectory Meadow Surgery: Travel risk assessment performed Yes / No

Signature: _____ Position: Practice Nurse Date: _____

I authorise administration of the above highlighted vaccine(s) to be given to the above named patient in accordance with Rectory Meadow Surgery **Patient Specific Directives**

GP signature: _____ Date: _____