

Personal details						
Name:			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		Length of stay		Away from medical help at destination, if so, how remote?		
1.						
2.						
Future travel plans						
Please tick as appropriate below to best describe your trip						
1. Type of trip	Business	<input type="checkbox"/>	Pleasure	<input type="checkbox"/>	Other	<input type="checkbox"/>
2. Holiday type	Package	<input type="checkbox"/>	Self organised	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>
	Camping	<input type="checkbox"/>	Cruise ship	<input type="checkbox"/>	Trekking	<input type="checkbox"/>
3. Accommodation	Hotel	<input type="checkbox"/>	Relatives/family home	<input type="checkbox"/>	Other	<input type="checkbox"/>
4. Travelling	Alone	<input type="checkbox"/>	With family/friend	<input type="checkbox"/>	In a group	<input type="checkbox"/>
5. Staying in area which is	Urban	<input type="checkbox"/>	Rural	<input type="checkbox"/>	Altitude	<input type="checkbox"/>
6. Planned activities	Safari	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Other	<input type="checkbox"/>
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 for example to eggs, antibiotics, nuts?						
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 or mental illness including depression or anxiety?						
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?						
Women only: Are you pregnant or planning pregnancy or breast feeding?						
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 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. 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	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		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Websites	Travel Record card supplied				
	Other				
Malaria prevention advice and malaria chemoprophylaxis					
Chloroquine and proguanil		Atovaquone + proguanil (Malarone)			
Chloroquine		Mefloquine			
Doxycycline		Malaria advice leaflet given			
Futher information					
e.g. weight of child					
Signed by:		Position:		Date:	

Now scan this form into the patient's record on the computer for evidence of best practice