

Patient ID



Length of appointment needed

## Torrington Health Centre TRAVEL RISK ASSESSMENT FORM

### Important

*We are unable to offer you an appointment if you hand this form back to us less than a month before your holiday.*

We will use our computer records for your immunisation status, if you have any immunisation cards or records at home please bring them with you to the appointment.

Please complete and return to reception as soon as possible, we will then contact you when the assessment has been made.

Personal details			
<b>Name:</b>	<b>Date of birth:</b> Male [ ] Female [ ]		
<b>Easiest contact telephone number</b>			
Dates of trip			
<b>Date of Departure</b>			
<b>Return date or overall length of trip</b>			
Itinerary and purpose of visit			
If you have a complicated itinerary please provide details on a separate sheet.			
<b>Country to be visited including cities and localities</b>	<b>Length of stay</b>	<b>Away from medical help at destination, if so, how remote?</b>	
1.			
2.			
3.			
4.			
Please tick as appropriate below to best describe your trip			
<b>1. Type of trip</b>	Business	Pleasure	Other
<b>2. Holiday type</b>	Package	Self organised	Backpacking
	Camping	Cruise ship	Trekking
<b>3. Accommodation</b>	Hotel	Relatives / family home	Other
<b>4. Travelling</b>	Alone	With family / friend	In a group
<b>5. Staying in area which is</b>	Urban	Rural	Altitude
<b>6. Planned activities</b>	Safari	Adventure	Other
<p><i>Women only: Are you pregnant or planning pregnancy or breast feeding?</i></p> <p>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.</p> <p>Signed _____ Date _____</p>			

Personal medical history		
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions, disorder)		
List any current or repeat medications, including recreational drug use.		
	Yes	No
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 of mental illness including depression or anxiety?		
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?		
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about his?		
Please write below any further information which may be relevant		

For official use			
Travel risk assessment performed Yes [ ] No [ ]			
TRAVEL VACCINES RECOMMENDED FOR THIS TRIP			
Disease protection	Advised	Needed by patient	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus/Diphtheria/Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
MMR			
Malaria			
TRAVEL ADVICE AND LEAFLETS NEEDED			
FUTHER INFORMATION			
e.g. weight of child			
<b>Signed by:</b>		<b>Position:</b>	<b>Date:</b>

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