Appendix 2: Travel risk assessment form

Please complete this form prior to your travel appointment and return to reception

Personal details

Name:

Date of Birth: Male ( ) Female ( )

Easiest contact telephone number:

Email:

Date 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.		
3.		

Please circle the description that best describes your trip

1.	Type of trip:	Business	Pleasure	Other
2.	Holiday type:	Package Camping	Self-organised Cruise ship	Backpacking Trekking
3.	Accommodation	Hotel	Relatives/family home	Other
4.	Travelling	Alone	With family/friend	In a group
5.	Staying in an area:	Urban	Rural	Altitude
6.	Planned activities	Safari	Adventure	Other

Personal medical history

Do you have any recent or past medical history of note: This includes diabetes, heart or lung conditions, thymus disorder.

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?

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Does having an injection make you feel faint?

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Do you or any close family members have epilepsy?

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Do you have any history of mental illness including depression or anxiety?

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Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

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Women only: Are you pregnant or planning pregnancy or breast feeding:

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Have you taken out travel insurance? If you have a medical condition have you informed the insurance company about this?

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Please give any further information that may be relevant, including any future travel plans.

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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

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Malaria tablets

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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, C and HIV ☐

Insect bite prevention ☐ Animal bites ☐ Accidents ☐ Insurance ☐ Air travel ☐

Sun and heat protection ☐ Hajj travel ☐ Travel record card supplied ☐ Websites ☐

Other ☐

Malaria prevention advice and malaria chemoprophylaxis

Chloroquine and proguanil ☐ Atavaquone + projuanil (Malorone) ☐

Chloroquine ☐ Mefloquine ☐ Doxycycline ☐ Malaria advice leaflet given ☐

Further information
e.g. weight of child

Signed by: Position: Date: