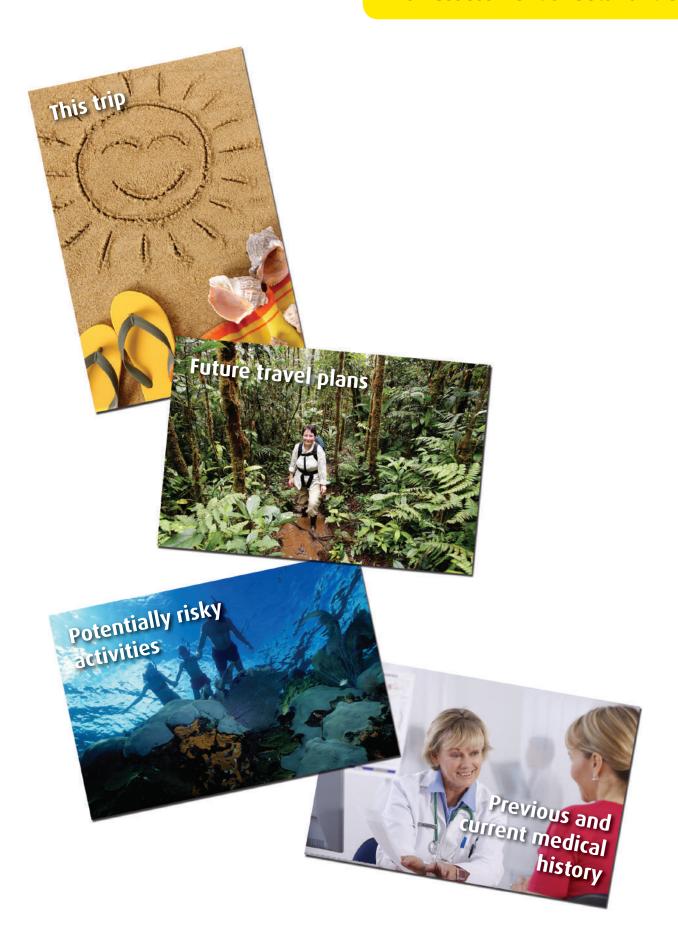
Risk assessment sheets for travel





UK/MARK/0288/11 28169265 Date of preparation: March 2011

Personal details							
Name				Date of birth			
				Male [] Female []			
Easiest contact telephone numbe E mail							
Dates of trip							
Date of departure							
Return date or overall length of tr							
Details about destination(s)							
Country <u>and</u> location to be visited			n of stay	Away from medical help at destination, if so, how remote?			
1.							
2.							
3.							
Do you plan to travel abroad agai	n in the future?	•					
Please tick as appropriate be	elow to best describe you	ur trip					
1. Type of trip	Business		Pleasure		Other		
2. Holiday type	Package		Self organised		Backpacking		
	Camping		Cruise ship		Trekking		
3. Accommodation	Hotel		Relatives/family home		Other		
4. Travelling	Alone		With family/frien	d	In a group		
5. Staying in area which is	Urban		Rural		Altitude		
6. Planned activities	Safari		Adventure		Other		
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 or latex?							
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 breastfeeding?							
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.								
				3 3				
Signed: Date:								
FOR OFFICIAL USE								
Patient Name:								
	at parformed	Voc []	No. []					
Travel risk assessmer			No []					
Travel vaccines re				الممط يبمد	eio o	Vassina appea dasa Cash	andula for DCD	
Disease protection Hepatitis A		Yes	No Patient dec	illied vaco	.ine	Vaccine name, dose & sch	ledule for PSD	
Hepatitis B								
Typhoid								
Cholera								
Tetanus								
Diphtheria								
Polio								
Meningitis ACWY		-+						
Yellow Fever								
Rabies								
Japanese B Encephali	tis							
Other								
Travel advice and	looflate aive	25.06	es traval acatacal					
Food, water and pers		en as pe	·			Blood and bodily fluid int	faction	
hygiene advice	Ulldi		mavellers diaminoed			risks e.g. Hepatitis B	lection	
Insect bite prevention	n		Animal bites			Accidents		
Insurance			Air travel		Sun and heat protection			
Websites			SMS vaccines remin	der servio	ice set up			
Travel record card supplied Other								
Malaria prevention advice and malaria chemoprophylaxis								
Chloroquine and proguanil Atovaquone + proguanil								
Chloroquine					Mefloquine Programm			
Doxycycline				Malaria advice leaflet given				
Further information								
e.g. weight of child								
Authorisation for Patient Specific Direction (PSD) Use								
$ \cdot $								
Name:Signature:Date:								
-								

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