

## COWPLAIN FAMILY PRACTICE

### TRAVEL RISK ASSESSMENT FORM

Please complete this form before your travel appointment and return it to reception

Personal details						
Name		Date of birth				
		Male <input type="checkbox"/>		Female <input type="checkbox"/>		
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.						
3.						
Please tick as appropriate below how best to 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	
	Camping	<input type="checkbox"/>	Cruise ship	<input type="checkbox"/>	Trekking	
3. Accommodation	Hotel	<input type="checkbox"/>	Relatives/ family home	<input type="checkbox"/>	Other	
4. Travelling	Alone	<input type="checkbox"/>	With family/friend	<input type="checkbox"/>	In a group	
5. Staying an area which is	Urban	<input type="checkbox"/>	Rural	<input type="checkbox"/>	At high altitude	
6. Planned activities	Safari	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Other	

## COWPLAIN FAMILY PRACTICE

### Personal medical history

1. Do you have any recent or past medical history of note? (including diabetes, heart or long conditions?)

2. List any current or repeat medications

3. Do you have any allergies (eg to eggs, antibiotics , nuts etc)?

4. Have you ever had a serious reaction to a vaccine you have received?

5. Does having an injection make you feel faint?

6. Do you or any close family members have epilepsy?

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

8. Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

9. Females only: Are you pregnant or planning pregnancy or are you breast feeding?

10. Have you taken out travel insurance and, if you have a medical condition have you informed the insurance company about this?

11. Please write below any further information which might be relevant

## COWPLAIN FAMILY PRACTICE

<b>Vaccination History</b>					
Have you ever had any of the following vaccinations or malaria tablets? Give dates if possible.					
Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow fever		Influenza	
Rabies		Japanese B encephalitis		Tick borne encephalitis	
Other					
Malaria tablets					

These are for discussion when the risk assessment is conducted during 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.

Signature .....

Date .....

<b>For official use.</b>	<b>Patient name</b>		
Travel risk assessment performed?      Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>TRAVEL VACCINES RECOMMENDED FOR THIS TRIP</b>			
Disease protection	Yes	No	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B encephalitis			
Other			

## COWPLAIN FAMILY PRACTICE

TRAVEL ADVICE AND LEAFLETS GIVEN IN ACCORDANCE WITH 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 information					

MALARIA PREVENTION ADVICE AND MALARIA CHEMOPROPHYLAXIS			
Chloroquine and proguanil		Atovaquone and proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	
<b>Further information</b> (eg weight of child)			
<b>Signed by</b> .....		<b>Position</b> .....	
		<b>Date</b> .....	

This form is to be scanned into the patient's record as evidence of best practice

### Patient Specific Directive

I, Dr ....., hereby authorise the above named patient to receive any/all of the following vaccines for the purpose of travel as detailed above;

- Rabies
- Japanese encephalitis
- Yellow fever
- Hepatitis A
- Tick-borne encephalitis
- Cholera

Signed..... Dated .....