Personal Details

Name: Date of Birth: / / Male ☐ Female ☐

Contact telephone no.:

E-Mail:

Dates of trip

Date of Departure:

Return date or overall length of trip:

Itinerary and purpose of visit

Country and location to be visited	Length of stay	Away from medical help at destination (Y/N), if so how remote?
1.		
2.		
3.		
4.		

Do you plan to travel abroad again in the future?

Please tick as appropriate below to best describe your trip

Type of trip	Business		Pleasure		Other	
Holiday type	Package		Self organised		Backpacking	
	Camping		Cruise ship		Trekking	
Accomodation	Hotel		Relatives/family home		Other	
Travelling	Alone		With family/friend		In a group	
Staying in area which is	Urban		Rural		Altitude	
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.)

Please list any current /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 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, if so when?					
Tetanus		Polio		Diptheria	
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	Pt declined vaccin	Vaccine name, dose & schedule for PSD
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	☐	SMS vaccines reminder service set up			☐
Travel Record card supplied	☐	Other			☐

Malaria Prevention Advice and Malaria Chemoprophylaxis			
Chloroquine and proguanil	☐	Atovaquone + proguanil (Malarone)	☐
Chloroquine	☐	Mefloquine	☐
Doxycycline	☐	Malaria advice leaflet given	☐

Further Information

e.g. weight of child

Authorisation for Patient Specific Direction (PSD) use

Name: Signature: Date:

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