Longfield Medical Centre
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THIS FORM **MUST** BE PLACED INTO THE NURSES TRAY TO BE ASSESSED.

# Travel risk assessment (Form A)

## To be completed by traveller prior to appointment.

Please complete this form prior to your travel appointment and return to reception to make an appointment. The Practice cannot provide travel vaccinations if less than 12 weeks' notification is given. You will need to contact either Springfield Hospital on 01245 234134 or Travel Health UK 01277 200169. **A charge of £30 + VAT will be made to patients who fail to attend their appointments. CASH PAYMENTS ONLY**

| | |
|---|---|
| Title (please tick one): | Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other: |
| Forename(s): | |
| Surname: | |
| Date of Birth: | |
| Current Address: (including postcode) | |
| | |
| | |
| Telephone/Mobile No: | |
| Email: | |

| **Please supply information about your trip in the sections below:** | | | |
|---|---|---|---|
| Date of Departure: | | | |
| Total Length of Trip: | | | |
| Country to be visited | Exact location or region | City or Rural | Length of Stay |
| | | | |
| | | | |
| | | | |
| Have you taken out travel insurance for this trip? | | | |
| Do you plan to travel abroad again in the future? | | | |

**Type of travel and purpose of trip – please tick all that apply**

| | | |
|---|---|---|
| ☐ Holiday | ☐ Staying in hotel | ☐ Backpacking |
| ☐ Business trip | ☐ Cruise ship trip | ☐ Camping/hostels |
| ☐ Expatriate | ☐ Safari | ☐ Adventure |
| ☐ Volunteer work | ☐ Pilgrimage | ☐ Diving |
| ☐Healthcare worker | ☐ Medical tourism | ☐ Visiting friends/family |

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Additional Information:

## Please supply details of your personal medical history

| | Yes | No | Details |
|---|---|---|---|
| Are you fit and well today | | | |
| Any allergies including food, latex, medication | | | |
| Severe reaction to a vaccine before | | | |
| Tendency to faint with injections | | | |
| Any surgical operations in the past, including eg your spleen or thymus gland removed | | | |
| Recent chemotherapy/radiotherapy/organ transplant | | | |
| Anaemia | | | |
| Bleeding/clotting disorders (including history of DVT) | | | |
| Heart disease (eg angina, high blood pressure) | | | |
| Diabetes | | | |
| Disability | | | |
| Epilepsy/seizures | | | |
| Gastrointestinal (stomach) complaints | | | |
| Liver and or kidney problems | | | |
| HIV/AIDS | | | |
| Immune system condition | | | |
| Mental health issues (including anxiety, depression) | | | |
| Neurological (nervous system) illness | | | |
| Respiratory (lung) disease | | | |
| Rheumatology (joint) conditions | | | |
| Spleen problems | | | |
| Any other conditions? | | | |
| **Women only** | | | |
| Are you pregnant? | | | |
| Are you breast feeding? | | | |
| Are you planning pregnancy while away? | | | |

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| **Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)? |
|---|
| |

| **Please supply information on any vaccines or malaria tablets taken in the past (inc. date if known)** | | | | | |
|---|---|---|---|---|---|
| Tetanus/polio/diphtheria | | MMR | | Influenza | |
| Typhoid | | Hepatitis A | | Pneumococcal | |
| Cholera | | Hepatitis B | | Meningitis | |
| Rabies | | Japanese Encephalitis | | Tick Borne Encephalitis | |
| Yellow fever | | BCG | | Other | |
| Malaria tablets | | | | | |
| | | | | | |

| Any additional information |
|---|
| |

**Authority to release information to a Representative**

| I hereby give my authority for …….…… to receive the information on this form | |
|---|---|
| Signature of Patient: | Date: |

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# Travel risk management (form B)

| **For health professional use only in conjunction with travel risk assessment Form A** |
|---|
| Patient name: Date of birth:<br><br>Childhood immunisation history checked:<br>Additional information: |
| **National database consulted** for travel vaccines recommended for this trip and malaria chemoprophylaxis (if required):<br><br>**NaTHNaC:** **TRAVAX:** **Other:** |

| **Disease protection advised** | **Yes** | **Disease protection advised** | **Yes** | **Malaria Chemoprophylaxis Recommendation** | **Yes** |
|---|---|---|---|---|---|
| BCG/Mantoux | | Influenza | | Atovaquone/proguanil | |
| Cholera | | Meningitis ACWY | | Chloroquine only | |
| Dip/tetanus/polio | | MMR | | Chloroquine and proguanil | |
| Hepatitis A | | Rabies | | Doxycycline | |
| Hepatitis B | | TBE | | Mefloquine | |
| Hepatitis A+B | | Typhoid | | Proguanil only | |
| Hepatitis A + Typhoid | | Yellow fever | | Emergency standby | |
| Japanese Encephalitis | | Other | | Weight of child: | |

| **Vaccine and General Travel Advice required/provided** | |
|---|---|
| Potential side effects of vaccines discussed<br><br>Patient Information Leaflet (PIL) from packaging or from www.medicines.org/emc/given | |
| Patient consent for vaccination obtained: ☐ verbal ☐ written | |
| Patient vaccination advice given: ☐ verbal ☐ written | |
| General travel advice leaflet given (all topics below in the surgery/clinic advice leaflet) and patient asked to read entire leaflet due to insufficient time to advise verbally on every topic: Yes / No | |
| **Items ticked below indicate topics discussed specifically within the consultation:** | |

| | | | |
|---|---|---|---|
| Prevention of accidents | | Mosquito bite prevention | |
| Personal safety and security | | Malaria prevention advice | |
| Food and water borne risks | | Medical preparation | |
| Travellers' diarrhoea advice | | Sun and heat advice | |
| Sexual health & blood borne virus risk | | Journey/transport advice | |
| Rabies specific advice | | Insurance advice | |

**Other specific specialised advice/information given on:**
e.g. smoking advice for a long haul flight; altitude advice; prevention of schistosomiasis etc.

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Source of advice used for further information: NaTHNaC TRAVAX Other

**OR** no additional specialised advice given ☐

**Additional patient management or advice taken following risk assessment – for example**

- Vaccine(s) patient declined following recommendation, and reason why
- Telephoned NaTHNaC or TRAVAX for advice or used Malaria Reference Laboratory fax service
- Contacted hospital consultant for specific information in respect of a complex medical condition
- Identified specific nature/purpose of VFR travel

**Authorisation for a Patient Specific Direction (PSD)**

Following the completion of a travel risk assessment, the below named vaccines may be administered under this PSD to

Name: DOB:

| | | Post vaccine records | |
|---|---|---|---|
| **Name of Vaccine** | **Dose and schedule** | **Batch number** | **Site given** |
| | | | RA LA<br>RL LL |
| | | | RA LA<br>RL LL |
| | | | RA LA<br>RL LL |
| | | | RA LA<br>RL LL |
| | | | RA LA<br>RL LL |
| | | | RA LA<br>RL LL |

| **Signature of Prescriber** | **Date** |
|---|---|
| | |

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**Post Vaccination administration**

| | |
|---|---|
| Vaccine details recorded on patient computer record (vaccine name, batch no, stage, site, etc.) | Y / N |
| SMS vaccines reminder or post card reminder service set up | Y / N |
| Travel record card supplied or updated | Y / N |
| **Travel risk management consultation performed by:** (sign name and date) | |