LONGFIELD MEDICAL CENTRE

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**

Name: Address:	Date of birth: ☐ Male ☐ Female Telephone no:
Email:	Mobile no:
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
1.			
2.			
3.			

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	Additional information
☐ Business trip	☐ Cruise ship trip	☐ Camping/hostels	
☐ Expatriate	☐ Safari	☐ Adventure	
☐ Volunteer work	☐ Pilgrimage	☐ Diving	
☐Healthcare worker	☐ Medical tourism	☐ Visiting friends/family	

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?			

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		
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:

Travel risk management (form B)

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

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 RL LL
			RA LA RL LL
			RA LA RL LL
			RA LA RL LL
			RA LA RL LL
			RA LA RL LL

Signature of Prescriber	Date

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)	