Longfield Medical Centre

Tel: 01621 876433 longfieldmedicalcentre.nhs.uk

Travel Risk Assessment (Form A)

to be completed by traveller prior to appointment

*The Practice cannot provide travel vaccinations **if less than 8 weeks' notification** is given.*

Please complete this form (one form per traveller) and return to Reception whereby it will be assessed by a Nurse and a telephone appointment will be arranged to discuss the requirements.

You are eligible to have a free assessment on the NHS.
The vaccines available on the NHS are Tetanus/Polio/Diphtheria, Cholera, Typhoid and Hepatitis A.

All other vaccines not available on the NHS will be subject to a one-off Admin Fee (as detailed below) plus the costs of the vaccines/course themselves.

£30.00 + VAT per adult	£15.00 + VAT per child (under 16)	Family of 4 Offer £80.00 + VAT
plus vaccine(s) costs	*plus vaccine(s) costs*	*plus vaccine(s) costs*

We are registered to administer Yellow Fever, and this is subject to an additional one-off Admin Fee per person (£50.00 + VAT) plus the cost of the vaccine itself.

ALL FEES ARE TO BE PAID BEFORE VACCINATION APPOINTMENTS CAN BE CONFIRMED AND VACCINATIONS ADMINISTERED. **CARD PAYMENTS OR BANK TRANSFER 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

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?			

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	Malaria Tablets	Other:

Please use this space for any other 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**
Cholera		Meningitis ACWY		Atovaquone/proguanil	
Dip/tetanus/polio		MMR		Chloroquine only	
Hepatitis A		Rabies		Chloroquine and proguanil	
Hepatitis B		TBE		Doxycycline	
Hepatitis A+B		Typhoid		Mefloquine	
Hepatitis A + Typhoid		Yellow fever		Proguanil only	
Japanese Encephalitis		Other		Emergency standby	
Influenza		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: Date of Birth:

		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
			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:

Print Name:

Signature: Date: