

Westongrove - TRAVEL RISK ASSESSMENT FORM

Please complete this form prior to your travel appointment and return to reception. A form for each family member is required.

Personal details		DATE:	
Name:		Male <input type="checkbox"/> Female <input type="checkbox"/>	
		DOB: _____ AGE: _____	
Easiest contact telephone number			
What practice you are registered at: Aston Clinton <input type="checkbox"/> Bedgrove <input type="checkbox"/> Wendover <input type="checkbox"/>			
Other (please state)			
Date of trip?		Date of Departure?	
Return date and overall length of trip			
Travel Destination	Length of stay	Remote destination	

Please tick as appropriate below to best describe your trip

Type of trip	Business <input type="checkbox"/>	Pleasure <input type="checkbox"/>	Other <input type="checkbox"/>
Holiday type	Package <input type="checkbox"/>	Self organised <input type="checkbox"/>	Backpacking <input type="checkbox"/>
	Camping <input type="checkbox"/>	Cruise ship <input type="checkbox"/>	Trekking <input type="checkbox"/>
Accommodation	Hotel <input type="checkbox"/>	Relatives/family/home <input type="checkbox"/>	Other <input type="checkbox"/>
Type of area	Urban <input type="checkbox"/>	Rural <input type="checkbox"/>	Altitude <input type="checkbox"/>
Planned activities	Safari <input type="checkbox"/>	Adventure <input type="checkbox"/>	Other <input type="checkbox"/>

Personal medical history

Do you have any recent or past medical history? (including diabetes, heart, lung , operations etc)
List any current or repeat medications
Do you have any allergies for example to eggs, antibiotics, nuts ?
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 of 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? If you have a medical condition have you informed the insurance company about this?
Please write below any further information which may be relevant

PTO

Vaccination History					
Have you ever had any of the following vaccinations / malaria tablets and if so when?					
Yellow Fever		Polio		Jap B Enceph	
Typhoid		Tetanus		Hepatitis B	
Hepatitis A		Diphtheria		Rabies	
Influenza		Meningitis		Tick Borne	
Other					
Malaria tablets					

I confirm that I am fit and well. I have no reason to think that I might be pregnant. I give my consent to the vaccines being given.

Signed _____ **Date** _____

After completing this form, it should be handed to the receptionist. This should be done before booking your nurse appointment to enable her to assess how many consultations and what immunisations will be required.

- We will then post the form back to you on completion (may take 2 weeks). You can then book the consultations necessary.
- **Payment must be made on arrival. Please ensure you arrive 10 minutes early to enable staff to process your payment.**
- **N.B.** If malaria tablets are required there is a separate private prescription charge.

For official use

TRAVEL VACCINES RECOMMENDED FOR THIS TRIP AND COST

Disease protection	Yes	No	Disease Protection	Yes	No
Hepatitis A			Yellow Fever		
Typhoid			Meningitis ACWY		
Tetanus			Rabies		
Diphtheria			Hepatitis B		
Polio			Japanese B Enceph		
Tickborne Enceph			Other		

Consultation only regarding Malaria		
Malaria tablets or discussion required with practice nurse		

Nurse appointment time	10 mins	20 mins	30 mins
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Please make your appointment at least _____ weeks prior to travel in travel clinic

Amount due: £.....

Signed by: _____ **Position:** _____ **Date:** _____

This form will act as a receipt: Therefore could you please bring it with you to all future travel consultations along with any travel vaccination cards that you might have. THANK YOU