|  |  |  |
| --- | --- | --- |
|  Pinfold Medical Practice |  | Pinfold GateLoughboroughLeicestershireLE11 1DQTel: 0844 477 1881Tel: 01509 274033Fax: 01509 568879www.pinfoldmedicalpractice.co.uk/ |

**We need at least 6-8 weeks before the time of travel to guarantee that the process can be completed. If you apply to us within a shorter notice period than this, you may be advised to seek travel vaccinations privately.**

*Patient Information - Travel Risk Assessment Form*

* Once the form is returned the nurse will check your electronic medical records, your paper medical records, and the conditions in the country(s) that you are travelling to. Depending on demand, availability and accessibility, this can take a little time, usually 1 week.
* The nurse will contact you once she has reviewed your records to arrange an appointment.
* Some vaccines are available on the NHS; some must be bought privately. Private vaccines need to be sourced and paid for independently. The nurse will be able to discuss this with you during your consultation.
* Some courses of vaccines take 2 weeks before they become effective. A full course of some vaccines may take longer. There are private clinics that might be able to help you speed things along in these circumstances.

*Bon voyage!*

|  |
| --- |
| **Personal Details** |
| NameDate of birth: | Male [ ] Female [ ] |
| Contact telephone numberEmail |  |
| **Trip information** |
| Date of departure |  |
| Return date or overall length of trip |  |
| **Details about destination(s)** |
| County and location  | Length of stay | Away from medical help at destination, if so, how remote? |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| Do you plan to travel abroad again in the future? |
| **Please tick as appropriate below the best way(s) to describe your trip** |
| *1 Type of trip* | Business |  | Pleasure |  | Other |  |
| *2. Holiday type* | Package |  | Self-organised |  | Backpacking |  |
| Camping |  | Cruise ship |  | Trekking |
| *3. Accommodation* | Hotel |  | Relatives/family home |  | Other |  |
| *4. Travelling* | Alone |  | With family/friend |  | In a group |  |
| *5. Staying in area which is* | Urban |  | Rural |  | Altitude |  |
| 6. *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) |
| List any current or repeat medications. |
| Do you have any allergies; for example to eggs, antibiotics, latex or 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, planning pregnancy or breastfeeding? |
| 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 and if so, when? |
| Tetanus |  | Polio |  | Diphtheria |  |
| 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:*

|  |
| --- |
| **CLINICAL USE** |
| Patient Name: |
| Travel risk assessment performed Yes [ ] No [ ] |
| **Travel vaccines recommended for this trip** |
| Disease protection | Yes | No | Patient declined vaccine | Vaccine name, dose & schedule for PSD |
| Hepatitis A |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Typhoid |  |  |  |  |
| Cholera |  |  |  |  |
| Tetanus |  |  |  |  |
| Diphtheria |  |  |  |  |
| Polio |  |  |  |  |
| Meningitis ACWY  |  |  |  |  |
| Yellow Fever |  |  |  |  |
| Rabies |  |  |  |  |
| Jap B Enceph |  |  |  |  |
| Other |  |  |  |  |
| **Travel advice and leaflets given as per travel protocol** |
| Food, water and personal hygiene advice |  | Travellers’ diarrhoea |  | Blood and bodily fluid infection risks e.g. Hepatitis B |  |
| 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 |  |
| Chloroquine |  | Melloquine |  |
| Doxycycline |  | Malaria advice leaflet given |  |
| **Further information**  |
| e.g. weight of child |
| **Authorisation for Patient Specific Direction (PSD) Use** |

***Office Use***

**Receptionist initials:**

**Date:**

Name: Signature: Date: