TRAVEL RISK ASSESSMENT FORM

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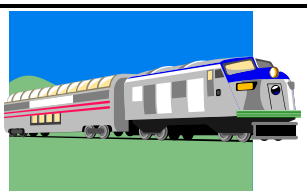

Dear Patient,

Please find attached the Travel Form for completion to enable the Nurse to give you correct and accurate advice on your Travel Vaccinations.

On return of the completed form please make an appointment to see one of the Nurses – the Surgery requires that you have a face to face appointment with a Nurse – even if you do not think that you need any vaccinations, as they are able to give you other relevant travel advice.

(We would prefer that you allow at least 5 working days between return of the form and your appointment in order to allow the nurses time to check what is required and look into your previous vaccinations on computer and paper records.)

If you have contacted the Surgery within four weeks of your leaving date – please be aware that we may not be able to deal with your requirements. We need the completed form, we may also need to order in vaccinations, and in some cases you need to start courses more than four weeks prior to your leaving date in order that they take effect.

If we are unable to help you – or you are contacting us very close to your leaving date we suggest that you contact

Masta - www.**masta-travel**-health.com/travelclinic/plymouthrravelclinic – Lisson Grove Medical Centre, 3-5 Lisson Grove Plymouth, PL4 7DL – Tel 0330 100 4288

Exeter Travel Clinic - www.**travel**healthconsultancy.co.uk -Travel Health Consultancy, 22 Southernhay West, Exeter, EX1 1PR Tel: 01392 430590

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NB – IF YOU ARE UNABLE TO ATTEND YOUR APPOINTMENT AT THE SURGERY PLEASE LET US KNOW AS YOU WILL BE GIVEN A DOUBLE APPOINTMENT.

Please complete prior to your appointment. **Ideally 6 – 8weeks before you travel.**

CATHERINE HOUSE SURGERY

Name:		**DOB:**	
		Male ☐	Female ☐
E Mail:		Telephone Number: Mobile number :	
PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTION 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 our 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 vaccine before			
Tendency to faint with injections			
Any surgical operations in the past, including e.g. your spleen or thymus gland removed			
Recent chemotherapy/radiotherapy/organ transplant			

Anaemia			
Bleeding/clotting disorders (including history of DVT)			
Heart disease (e.g. angina, high blood pressure)			
Diabetes			
Disability			
	YES	**NO**	**DETAILS**
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 breastfeeding			
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

TRAVEL RISK ASSESSMENT FORM

FOR HEALTH PROFESSIONAL USE ONLY IN CONJUNCTION WITH TRAVEL RISK ASSESSMENT FORM

Patient Name: **DOB:**

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/tet/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:**	

Vaccines in Bold/italics incur a cost – please see attached list.

Vaccine and General Travel Advice required/provided

Potential side effects of vaccines discussed:

Patient information Leaflet from packaging or from www.medicines.org.uk/emc/ GIVEN:

Patient consent for vaccination obtained:	verbal ☐	written ☐
Post 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 • Telephone 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 no.	Site given
Signature of Prescriber		**Date**	

Y	**N**	**Post Vaccination administration**
		Vaccine details recorded on patient computer record (vaccine name,batch, stage, site, etc.)
		Recall/reminder set up
		Travel record card supplied or updated:
		Travel risk management consultation performed by: Sign name and date

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VACCINE	COST	DOSES	FEE DUE
Cholera	NHS PRESCRIPTION		
Hepatitis B	£40 PER DOSE		
Japanese Encephalitis	£75 PER DOSE		
Meningitis ACWY	£45		
Rabies	£50 PER DOSE		
TBE	£50 PER DOSE		
Yellow Fever			LEATSIDE SURGERY
Atovaquone/proguanil	NOT NHS		
Chloroquine only			
Chloroquine and proguanil	SOME AVAILABLE FROM PHARMACY		
Doxycycline	SOME NEED PRIVATE PRESCRIPTION		
Mefloquine			
Proguanil only			
Administration Fee			£10.00
TOTAL DUE			

NURSE TO COMPLETE THE ABOVE PART OF FORM – PATIENT TO PAY AT RECEPTION PLEASE.

PLEASE MAKE CHEQUES PAYABLE TO CATHERINE HOUSE SURGERY.

TRAVEL CLINIC PATIENT CONSENT FORM

Patient Name: …….

Traveling to the following countries: …….

…….

…….

I have provided the Practice Nurse with details of my travel itinerary requirements and I have received and understood the advice given to me concerning:-

- My travel vaccination requirements for the location(s) I will be visiting
- What anti-malarial prophylaxis is recommended for the location(s) I will be visiting
- Any general preventative measures regarding travel health relating to the location of my visit

for myself &/or my child/children (name of child ……..)

Patient Signature: DATE:

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below. 1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine. RCN, London. www.rcn.org.uk 2. Field VK, Ford L, Hill DR, eds. (2010) Health Information for Overseas Travel. National Travel Health Network and Centre, London, UK. Form devised and created by Jane Chiodini © updated 2017