

TRAVEL RISK ASSESSMENT FORM –Please complete this prior to your appointment.

Name:		Date of birth	
		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Mobile number:		Telephone number:	
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			
<input type="checkbox"/> Holiday	<input type="checkbox"/> Staying in hotel	<input type="checkbox"/> Backpacking	<u>Additional information</u>
<input type="checkbox"/> Business trip	<input type="checkbox"/> Cruise ship trip	<input type="checkbox"/> Camping/hostels	
<input type="checkbox"/> Expatriate	<input type="checkbox"/> Safari	<input type="checkbox"/> Adventure	
<input type="checkbox"/> Volunteer work	<input type="checkbox"/> Pilgrimage	<input type="checkbox"/> Diving	
<input type="checkbox"/> Healthcare worker	<input type="checkbox"/> Medical tourism	<input type="checkbox"/> Visiting friends/family	
PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY			
	YES	NO	DETAIL
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 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			
Epilepsy/seizures			
Gastrointestinal (stomach) complaints			
Liver and or kidney problems			
HIV/AIDS			
Immune system condition			

	YES	NO	DETAIL
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?			
Have you undergone FGM / been cut / circumcised			

Are you currently taking any medication? (including prescribed, purchased or a contraceptive pill)?

PLEASE SUPPLY INFORMATION PERTAINING TO 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

Please complete this form and return it to reception. The practice nurses will review your form and carry out a risk assessment based on the information you have provided. A copy providing details of vaccine recommendations and a vaccine invoice if necessary will be available for you to collect from reception after a week.

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

- 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
- Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.