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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION ONE** - TO BE COMPLETED BY PATIENT | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | DOB: | | | | | | | | | | Sex: | | | | | |
| Male  Female | | | | | |
| Address: | | | | | | | GP:  GP Address: | | | | | | | | | | | | | | | |
| Postcode: | | | | | | | Postcode: | | | | | | | | | | | | | | | |
| Tel No. | | | | | | | Tel No. | | | | | | | | | | | | | | | |
| Current Health Problems: | | | | | | | Past Medical History of note? Or currently undergoing chemotherapy/ radiotherapy/ steriod treatment?: | | | | | | | | | | | | | | | |
|
|
| Current Medication: | | | | | | | Allergies (e.g. eggs, antibiotics, nuts,latex): | | | | | | | | | | | | | | | |
|
|
| Have you ever had a serious reaction to a vaccine given to you before?  Yes  No | | | | | | | Pregnancy? Yes  No. of weeks: | | | | | | | | | | | | | | | |
|  | | | | | | | No  N/A | | | | | | | | |
| **TRAVEL DETAILS**: (in order first to last) | | | | Date of Departure: | | | | | | | | | | | | | | Total duration: | | | | |
| ***Destination*** | | | | | | | | | | | | | ***Length of Stay*** | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | |
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|  | | | | | | | | | | | | |  | | | | | | | | | |
| **Type of trip** (please tick all that apply) | | | | | | | | | | | | | | | | | | **Areas Visiting** | | | **Accommodation** | |
| Travelling with Family | | Travelling with Friends | | | | | | | Travelling Alone | | | | | | | | | Urban    Rural    Altitude    Beach | | | Good    Basic    Poor    Not Known | |
| Package Holiday | | Immigration | | | | | | | Voluntary/ Charity Work | | | | | | | | |
| Cruise | | Organised Adventure | | | | | | | Elective/ Student | | | | | | | | |
| Business <3 Months | | Backpacking | | | | | | | Aid Worker | | | | | | | | |
| Business >3 Months | | Visiting family/friends | | | | | | | Self Organised | | | | | | | | |
| Occupation/Activities Abroad: | | | | | | | | | | | | | | | | | | | | | | |
|
|
| **Vaccination History** Have you ever had any of the following vaccinations / malaria tablets and if so when? | | | | | | | | | | | | | | | | | | | | | | |
| Tetanus |  | | Meningitis | | | | | | |  | | | | | Hepatitis A | | | | |  | | |
| Polio |  | | Yellow Fever | | | | | | |  | | | | | Hepatitis B | | | | |  | | |
| Diphtheria |  | | Influenza | | | | | | |  | | | | | Jab B Enceph | | | | |  | | |  |
| Typhoid |  | | Rabies | | | | | | |  | | | | | Tick Borne | | | | |  | | |
| Other: | | | | | | | | | | | | | | | | | | | | | | |
| Malaria Tablets: | | | | | | | | | | | | | | | | | | | | | | |
| **PLEASE NOTE**: Some Vaccines/Malaria Tablets are not covered by the NHS and will incur a charge; this will be discussed before the vaccines are given. There may be a charge for private patients. | | | | | | | | | | | | | | | | | | | | | | |
| **PLEASE BRING THE COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT WITH THE TRAVEL NURSE.**  **SECTION TWO -** TO BE COMPLETED BY HEALTHCARE PROFESSIONAL | | | | | | | | | | | | | | | | | | | | | |
| Patient Name: | | | | | | | | | | | | | | | | | | | | | |
| Patient Advised of Possible Private Charge? Yes  No | | | | | | | | | | | | | | | | | | | | | |
| Travel Risk Assessment Performed Yes  No | | | | | | | | | | | | | | | | | | | | | |
| ‘I Consent to the Vaccinations being Given’ Patient Signature: | | | | | | | | | | | | | | | | | | | | | |
| **Travel vaccines recommended for this trip \****Possible private cost, not covered by NHS* | | | | | | | | | | | | | | | | | | | | | |
| Disease Protection | | | | | Yes | | | No | | | | Patient Declined | | | | Further Information/ Schedule | | | | | |
| Hepatitis A | | | | |  | | |  | | | |  | | | |  | | | | | |
| Hepatitis B\* | | | | |  | | |  | | | |  | | | |  | | | | | |
| Typhoid | | | | |  | | |  | | | |  | | | |  | | | | | |
| Cholera | | | | |  | | |  | | | |  | | | |  | | | | | |
| Tetanus | | | | |  | | |  | | | |  | | | |  | | | | | |
| Diphtheria | | | | |  | | |  | | | |  | | | |  | | | | | |
| Polio | | | | |  | | |  | | | |  | | | |  | | | | | |
| MMR (Measles, Mumps, Rubella)\* | | | | |  | | |  | | | |  | | | |  | | | | | |
| Meningitis ACWY\* | | | | |  | | |  | | | |  | | | |  | | | | | |
| Yellow Fever\* | | | | |  | | |  | | | |  | | | |  | | | | | |
| Rabies\* | | | | |  | | |  | | | |  | | | |  | | | | | |
| Japanese B Encephalitis\* | | | | |  | | |  | | | |  | | | |  | | | | | |
| Other | | | | |  | | |  | | | |  | | | |  | | | | | |
| **Malaria Prevention advice and malaria chemoprophylaxis\*** | | | | | | | | | | | | | | | | | | | | | |
| Chloroquine and proguanil | | | | | |  | | | | | Atovaquone + Proguanil | | | | | | | | |  | |
| Chloroquine | | | | | |  | | | | | Mefloquine | | | | | | | | |  | |
| Doxycycline | | | | | |  | | | | | Malaria advice leaflet given | | | | | | | | |  | |
| **Travel Advice/ Risks Discussed/ Leaflets given** | | | | | | | | | | | | | | | | | | | | | |
| **Advice/Risk** | | **Yes No N/A** | | | | | | | **Advice/Risk** | | | | | | | | | | **Yes No N/A** | | |
| Bite Avoidance | |  | | | | | | | Schistosomiasis | | | | | | | | | |  | | |
| Food/Water Hygiene | |  | | | | | | | Insurance/Accidents | | | | | | | | | |  | | |
| Blood Borne Viruses | |  | | | | | | | Sun Protection | | | | | | | | | |  | | |
| Rabies | |  | | | | | | | Air Travel | | | | | | | | | |  | | |
| Traveler's Diarrhoea | |  | | | | | | | Bodily Fluid Infections | | | | | | | | | |  | | |
| Other (Please Specify) | | | | | | | | | | | | | | | | | | | | | |
| **Further Information** | | | | | | | | | | | | | | | | | | | | | |
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|
| Completed By: | | | | | | | | | | | | Date: | | | | | | | | | |
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