

## Denmark Street Surgery – Travel Risk Assessment Form

### Vaccination History

Have you ever had any of the following vaccinations/malaria tablets and if so when?

Tetanus		Polio	
Typhoid		Hepatitis A	
Meningitis		Yellow Fever	
Rabies		Jap B Enceph	

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 had the opportunity to ask questions. I consent to the vaccinations being given.

Signed ..... Date.....

### FOR OFFICAL USE

Patient name:

Travel risk assessment performed    yes ( )    no ( )

### Travel vaccines recommended for this trip

Disease Protection	Yes	No	Further Information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Jap B Enceph			
Other			

### Travel Advice and leaflets as per travel protocol

Food water and personal hygiene advice		Travellers diarrhoea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Travel Record supplied		Websites		Other	

### Malaria prevention advice and malaria chemoprophylaxis

Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria	

### Further Information

e.g weight of child

Signed by:..... Position..... Date.....

**For official use only:**    Please tick    Seen by nurse ..... Patient informed ..... Scan to notes .....

## Denmark Street Surgery – Travel Risk Assessment Form

Personal Details			
Name		Date of birth	
Address			
Easiest contact number:		Male ( ) Female ( )	
Dates of trip			
Date of departure			
Return date or overall length of trip			
Itinerary and purpose of visit			
Country to be visited		Length of stay	Away from medical help at destination, if so how far?
1.			
2.			
Future travel plans			
Please tick as appropriate below to best 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/friends	In a group
5. Staying 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? (include diabetes, heart, lung conditions)			
List any current repeat medications			
Have you ever had 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?			
Have you recently undergone radiotherapy, chemotherapy, or steroid treatment?			
<b>Women only:</b> Are you pregnant or planning pregnancy or breast feeding?			
Have you taken out travel insurance and if you have a medical condition, have you informed the insurance company about this?			
Please write below any further information which may be relevant			
<b>For official use only:</b> Please tick    Seen by nurse ..... Patient informed ..... Scan to notes .....			