

South Milford Surgery Travel Health Risk Assessment Form

To enable us to make a full risk assessment for your trip, it is crucial that you complete this form with as much detail as possible and return to the surgery as soon as you can. **INCOMPLETE FORMS CANNOT BE PROCESSED.** We aim to have your individualised information available to collect after 3 working days. **IT NEEDS TO BE COLLECTED AND READ** before attending any appointments for injections so that you are fully informed of your travel needs.

This form will be attached to your medical records

Personal Details

*please delete as appropriate

Surname: First Name:

Date of Birth: * Male * Female

Address:

Easiest contact telephone number:

Dates of Trip

Date of departure:

Return date or overall length of trip:

Itinerary and purpose of trip

Country(s) to be visited Including City/area	Length of Stay	Away from medical help at destination? If so, how remote?
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Please tick the descriptions that best describes your trip

Type of trip	Business	Pleasure	Other
Holiday type	Package	Self-organised	Backpacking
	Camping	Cruise ship	Visiting family/friends
	Other		
Accommodation	Hotel	Relatives/family home	Other
Travelling	Alone	Partner/friend/family	In a group
Staying in area which is	Urban	Rural	Altitude
Planned activities	Safari	Adventure	Other

Personal medical history

Do you have any current or past medical history of note? This includes diabetes, heart or lung conditions, thymus disorder, mental health problems: *Yes *No

If yes, please give details.

List any current or repeat medications including contraceptive pill.

Are you allergic to or have you reacted badly to medicines, antibiotics, eggs or previous vaccines?

*Yes *No If yes, please give details

Does having an injection make you feel faint? *Yes *No

Have you undergone radiotherapy, chemotherapy or steroid treatment? *Yes *No

If yes, please give details

Women only: Are you pregnant or planning pregnancy or breast-feeding? *Yes *No

If yes, please give details

Do you have any history of mental illness including depression or anxiety? *Yes *No

If yes, please give details

Please give any further information that you feel may be relevant, including future travel plans

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Vaccination History

Have you ever had any of the following vaccinations/malaria tablets, and if so, when? List all relevant dates.

	Date	Staff use only		Date	Staff use only		Date	Staff use only
Tetanus			Hepatitis A			Hepatitis B		
Diphtheria			Typhoid			Rabies		
Polio			Yellow Fever			Influenza		
Tick Borne Encephalitis			Jab B Encephalitis			Meningitis ACWY		
			Malaria tablets			Other Specify		

Please provide as much information as possible so that we can give you appropriate advice and injections.

WE NOW HAVE DEBIT OR CREDIT CARD FACILITIES AT THE CLINIC THEREFORE PAYMENT IS BY CASH OR CHEQUE WITH GUARANTEE CARD OR CREDIT/DEBIT CARD. PAYMENT MUST BE MADE IN FULL BEFORE THE INJECTIONS ARE GIVEN.

Thank you.