SOUTHBANK SURGERY Travel Form

Due to increased demand for travel advice, these forms can take up to 6 weeks to be processed. If you are travelling sooner than this you may need to use a commercial Travel Clinic

Name: Date of birth: Female ()	Personal details						
Easiest contact telephone number: Dates of trip Date of departure: Return date or overall length of trip: Details about destination(s) Country and location to be visited Length of stay: Away from medical help at destination? If so, how remote? 1. 2. 3. Do you plan to travel abroad again in the future? Please tick as appropriate below to best describe your trip 1. Type of trip Business Pleasure Other Hotel Relatives home Other 3. Accommodation Hotel Relatives home Other A. Travelling Alone With family/friend In a group Staying in area which is Safari Adventure Other Personal medical history Do you have any recent past medical history of note? (including diabetes, heart or lung conditions) List any current or repeat medicat history of note? (including diabetes, heart or lung conditions) List any current or repeat medications: Do you have any allergies, for example to eggs, antibiotics, nuts or latex? Have you ever had a serious reaction to a vaccine given to you before? Does having an injection make you feel faint? Do you have any history of mental illness? (including depression or anxiety) Have you recently undergone radiotherapy, chemotherapy or steroid treatment? Women only: Are you pregnant or planning pregnancy or breastfeeding? Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?	Name: Date of birth:			Male ()			
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this?							
Please write below any further information which may be relevant							

Vaccination history								
Have you ever had any of the following vaccinations / malaria tablets and if so when?								
Tetanus		Poli	0			Diphtheria		
Typhoid		Нер	atitis A			Hepatitis B		
Meningitis		Yello	ow Fever			Influenza		
Rabies		Jap	B Enceph			Tick Borne		
Other								
Malaria Tablets								
vaccines recommended and ha				sk questions		ent to the vaccines	bein	ig given.
FOR OFFICIAL USE								
Patient Name:								
Travel risk assessment perform			Yes	()		No	()
Travel vaccines recommended	for thi	s trip						
Disease protection	Yes	No	Patient decli	ned vaccine	Vacci	ne name, dose & so	chedu	ıle for PSD
Hepatitis A								
Hepatitis B								
Typhoid								
Cholera								
Tetanus								
Diphtheria								
Polio								
Meningitis ACWY	<u> </u>							
Yellow fever	<u> </u>							
Rabies	<u> </u>							
Japanese B Encephalitis								

Japanese B Encephantis							
MMR							
Other							
Travel advice and leaflets given as per travel protocol							
Food, water and personal hygiene		Travellers' diarrhoea	Blood and bodily fluid				
advice			infection risks eg Hep B				
Insect bite prevention		Animal bites	Accidents				
Insurance		Air travel	Sun and heat protection				
Websites		SMS vaccines reminder service set up					
Travel record card supplied							
Malaria prevention advice and malaria chemoprophylaxis							

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Chloroquine and proguanil	Atovaquone and proguanil					
Chloroquine	Mefloquine					
Doxycycline	Malaria advice leaflet given					
Further information						

eg weight of child

Authorication	for Dationt	Specific Direction	(DCD) Hea
authorisation	ioi Patient	Specific Direction	Tradi Use

Signature _ Date _ Name _