

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

Personal details					
Name:		Date of birth: ____/____/____		Male () Female ()	
Easiest contact telephone number:				Email address:	
Dates of trip					
Date of departure:					
Return date or overall length of trip:					
Details about destination(s)					
Country <u>and</u> 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
2. Holiday type	Package		Self-organised		Backpacking
	Camping		Cruise ship		Trekking
3. Accommodation	Hotel		Relatives home		Other
4. Travelling	Alone		With family/friend		In a group
5. Staying in area which is	Urban		Rural		Altitude
6. Planned activities	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 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 or any close family members have epilepsy?					
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?					
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		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
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 have had the opportunity to ask questions. I consent to the vaccines being given.

Signed _____

Date _____

FOR OFFICIAL USE					
Patient Name:					
Travel risk assessment performed		Yes ()		No ()	
Travel vaccines recommended for this trip					
Disease protection	Yes	No	Patient declined vaccine	Vaccine name, dose & schedule for PSD	
Hepatitis A					
Hepatitis B					
Typhoid					
Cholera					
Tetanus					
Diphtheria					
Polio					
Meningitis ACWY					
Yellow fever					
Rabies					
Japanese B Encephalitis					
MMR					
Other					
Travel advice and leaflets given as per travel protocol					
Food, water and personal hygiene advice			Travellers' diarrhoea		Blood and bodily fluid 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					
Chloroquine and proguanil			Atovaquone and proguanil		
Chloroquine			Mefloquine		
Doxycycline			Malaria advice leaflet given		
Further information					
eg weight of child					
Authorisation for Patient Specific Direction (PSD) Use					
Name _____		Signature _____		Date _____	