| **Personal details** | |
|---|---|
| Name | Date of birth<br>Male [ ] Female [ ] |
| Contact telephone number<br>Email | |
| **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 | |
| 2. Holiday type | Package | | Self organised | | Backpacking | |
| | Camping | | Cruise ship | | Trekking | |
| 3. Accommodation | Hotel | | Relatives/family 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 or 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 egg, 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 or 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 Bourne | |
| Other | | | | | |
| Malaria Tablets | | | | | |

For discussion when risk assessment is performed within your appointment:

I have no reason to think 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: | Emis: |
| Travel risk assessment performed Yes [ ] No [ ] | |

| **Travel vaccines recommended for this trip** | | | | |
|---|---|---|---|---|
| Disease protection | Yes | No | Patient decline vaccine | Vaccine name, dose & schedule for PSD |
| Hepatitis A | | | | |
| Hepatitis B | | | | |
| Typhoid | | | | |
| Cholera | | | | |
| Tetanus | | | | |
| Diphtheria | | | | |
| Polio | | | | |
| Meningitis ACWY | | | | |
| Yellow Fever | | | | |
| Rabies | | | | |
| Japanese B Encephalitis | | | | |
| Other | | | | |

| **Travel advice and leaflets given as per travel protocol** | | | | | |
|---|---|---|---|---|---|
| Food, water and personal hygiene advice | | Travellers' diarrhoea | | Accidents and crime | |
| Insect bite prevention | | Sun and heat protection | | Travel insurance & EHIC | |
| Yellow fever | | DVT | | | |
| Travel record care supplied | | Other | | | |

| **Malaria prevention advice and malaria chemoprophylaxis** | | | |
|---|---|---|---|
| Chloroquine and proguanil | | Atovaquone + proguanil | |
| Chloroquine | | Mefloquine | |
| Doxycycline | | Malaria advice leaflet given | |

| **Further Information** |
|---|
| e.g. weight of child |

| **Authorisation for Patient Specific Direction (PSD) Use** |
|---|
| Name:_____ Signature:_____ Date_____ |