|  |  |  |
| --- | --- | --- |
|  |  |  |

TRAVEL RISK ASSESSMENT FORM

**This form can be completed prior to your travel appointment to help the Nurse with your travel risk assessment.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal details:** | | | | | | | | | | | | | | |
| Name |  | | | | Date of birth | | | | | | | | | |
| Contact Tel No: |  | |  | | Male | | |  | Female | | |  |  | |
| **Dates of trip:** | | | | | | | | | | | | | | |
| Date of departure | | | | | | | | | | | | | | |
| Return date or overall length of trip | | | | | | | | | | | | | | |
| **Itinerary and purpose of visit:** | | | | | | | | | | | | | | |
| Country **and** location to be visited | Length of stay | | | | | | Away from medical help at  destination, if so, how remote? | | | | | | | |
| 1. |  | | | | | |  | | | | | | | |
| 2 |  | | | | | |  | | | | | | | |
| 3 |  | | | | | |  | | | | | | | |
| **Please tick as appropriate below to best describe your trip:** | | | | | | | | | | | | | | |
| 1. Type of trip | | Business | |  | | Pleasure | | | |  | Other - Please specify | | |  |
| 2. Holiday type | | Package | |  | | Self organised | | | |  | Backpacking | | |  |
| 3. Mode of transport | | Plane | |  | | Bus | | | |  | Other- Please specify | | |  |
| 4. Accommodation | | Hotel | |  | | Relatives/family home | | | |  | Other- Please specify | | |  |
| 5. Travelling | | Alone | |  | | With family/friend | | | |  | In a group | | |  |
| 6. Staying in area which is | | Urban | |  | | Rural | | | |  | Altitude | | |  |
| 7. Planned activities | | Safari | |  | | Adventure | | | |  | Other- Please specify | | |  |

|  |
| --- |
| **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 eggs, antibiotics, nuts or latex? |
| Have you ever had a serious reaction to a vaccine given to you before? |
| Does having an injection make your 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 breast-feeding? |
| 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  Encephalitis |  |
| Other- Please specify |  | | | | |
| Malaria tablets |  | | | | |

|  |
| --- |
| ***Travel history:*** |
| Please specify what travelling experience you have: |