

THE CHIPPING SURGERY TRAVEL RISK ASSESSMENT

Please complete this form and return it at least a week prior to your appointment. IT DOESN'T REPLACE THE NEED FOR AN APPOINTMENT. We need to know exactly where you are going in the country.

Personal Details	
Name:	Date of Birth:
Easiest contact telephone No.:	
E-Mail:	

Dates of Trip	
Date of departure:	Return Date:

Itinerary & Purpose of Visit		
Country visiting	Length of stay	Away from medical help, if so, how remote?
1.		
2.		
3.		
4.		

Please ticks as appropriate below to best describe your trip.

1. Type of trip?	Business		Pleasure		Other	
2. Holiday type?	Package		Self organised		Back Packing	
	Camping		Trekking		Cruise ship	
3. Accommodation?	Hotel		Relatives/family home		Other	
4. Travelling?	Alone		With friends/family		In group	
5. Staying in an area which is?	Urban		Rural		Altitude	

Personal information needed for the Travel Assessment

1. Have you any allergies? (Eggs, nuts, antibiotics etc).	
2. Ladies only, are you pregnant, planning a pregnancy or breast feeding?	
3. Do you or close relatives have epilepsy?	
4. Have you recently undergone radiotherapy, chemotherapy, or steroid treatment?	
5. Do you have any history of mental illness including depression or anxiety? Or a close relative who has?	
6. Have you taken out insurance and if you have any medical conditions, informed the insurance company about these?	
7. Any other relevant information?	

FOR SURGERY TO COMPLETE.

NAME:

VACCINATIONS	RECOMMENDED	DATE OF PREVIOUS VACCINATIONS	NEEDED	COVERED
REVAXIS (TETANUS/DIPHtheria/POLIO)				
POLIO				
HEP A 1 ST				
HEP A BOOSTER				
HEPATITIS A & B				
HEPATITIS A & TYPHOID				
TYPHOID				
HEPATITIS B *				
YELLOW FEVER *				
RABIES *				
JAP. B ENCEPHALITIS**				
TICK BOURNE ENCEPHALITIS**				
MENINGITIS ACWY *				
OTHERS				
NO RECOMMENDATIONS				

*denotes that these vaccinations are not available on the NHS, and will involve a charge, if you wish to proceed & may involve a course of vaccinations. ** denotes unavailable at the surgery.

I GIVE PERMISSION FOR THE ABOVE VACCINATIONS TO BE GIVEN.

DOCTOR'S SIGNATURE..... DATE.....

MALARIA PREVENTION ADVICE & CHEMOPROHLAXIS

CHLOROQUINE & PROGUANIL		MALARONE	
CHLOROQUINE		LARIUM	
DOXYCLINE		NUMBERS REQUIRED	
BITE PREVENTION ONLY		MALARIA LEAFLETS GIVEN	
CHILD'S WEIGHT	KGS		

I have no reason to think I might be pregnant, or planning a pregnancy during the trip. I have received information on the risks & benefits of the vaccines recommended & have had opportunity to ask questions. I consent to the vaccines being given.

Signature: Print Name: Date: