Deansgrange Medical Centre

TRAVEL RISK ASSESSMENT FORM

Name:	Your country of origin:
Telephone number:	Date of birth:
Email:	Male □ Female □
Date of departure:	Occupation:
Have you travel insurance for this trip? **Y/N**	Do you plan to travel abroad again in future? **Y/N**

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW

COUNTRY TO BE VISITED (including transit/stopover)	EXACT LOCATION OR REGION	LENGTH OF STAY
1.		
2.		
3.		

TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY

□ Holiday	□ Staying in hotel	□ Cruise ship	**Additional Information**
□ Business trip	□ Backpacking	□ Pilgrimage	
□ Expatriate	□ Camping	□ Adventure	
□ Volunteer work	□ Hostels	□ Safari	
□ Healthcare worker	□ Visiting friends/family	□ Diving	
	□ Altitude/Climbing	□ Medical Tourism	

PLEASE SUPPLY DETAILS OF YOUR MEDICAL HISTORY, HAVE YOU ANY CONDITION LISTED BELOW?

	YES	NO	DETAILS
Are you fit and well today?			
Any allergies including food, latex, medication?			
Severe reaction to a vaccine before?			
Tendency to faint with injections?			
Any surgical operations in the past, including e.g. your spleen or thymus gland removed?			
Recent chemotherapy/radiotherapy/organ transplant?			
Anaemia?			
Bleeding /clotting disorders (including history of DVT)?			
Heart disease (e.g. angina, high blood pressure)?			
Diabetes?			
Disability?			
Epilepsy/seizures?			
Gastrointestinal (stomach) complaint?			
Liver and/or kidney problems?			
HIV/AIDS?			
Immune system condition?			
Mental health issues (including anxiety, depression)?			
Neurological (nervous system) illness?			
Respiratory (lung) disease?			
Rheumatology (joint) conditions?			
Spleen problems?			
Any other conditions?			
WOMEN ONLY			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			

HAVE YOU EVER HAD ANY VACCINATIONS OR MALARIA TABLETS BEFORE?, AND IF SO WHEN?

	Year		Year		Year
Tetanus		Hepatitis B		Japanese encephalitis	
Diptheria		Meningitis		Tick borne encephalitis	
Polio		Yellow fever		MMR	
Hepatitis A		Rabies		BCG	
Typhoid		Influenza		Other	
Cholera		Pneumococcal			
Malaria tablets before? Y/N		If yes, which tablets?			

I am not pregnant. I have received information on the risks and benefits of recommended vaccines and have had the opportunity to ask questions. I consent to the vaccines being given.

SIGNED_____ **DATE**_____

FOR OFFICIAL USE

TRAVEL VACCINES RECOMMMENDED FOR THIS TRIP AND MALARIA CHEMOPHOPHYLAXIS

DISEASE PROTECTION ADVISED	YES	COMMENTS	MALARIA CHEMOPROPHYLAXIS	YES
BCG/Mantoux			Atorvaquone/proguanil	
Cholera			Chloroquine only	
Diptheria/Tetanus/Polio			Chloroquine and proguanil	
Hepatitis A			Doxycycline	
Hepatitis B			Mefloquine	
Influenza			Proguqnil only	
Japanese encephalitis			Emergency Standby	
Meningitis ACWY			Weight of Child	
MMR			**TRAVEL PRESCRIPTION**	
Rabies			Fucibet	
Tick Bourne Encephalitis			DEET 50%	
Typhoid			Antihistamine	
Yellow Fever			Loperamide	
Other			Dioralyte	

TRAVEL ADVICE AND LEAFLET GIVEN, PATIENT ASKED TO READ ENTIRE LEAFLET DUE TO INSUFFICENT TIME TO ADVISE VERBALLY ON EVERY TOPIC, SPECIFIC TOPICS DISCUSSED BELOW

Accident prevention		Sexual health risks		Medical preparation	
Personal safety/ security		HIV /Hepatitis B		Sun and heat advice	
Food and water borne risks		Insect bite prevention		Journey and transport advice	
Travellers diarrhoea advice		Malaria prevention		Insurance	
Altitude advice		Rabies specific advice		Zika/Dengue/Chikun/Schisto	

Database consulted: TRAVAX / NaTHNaC		
Temperature	No Contraindiacations	
Childhood immunisations checked		Y/N
Vaccine and travel advice given and leaflet given		Y/N
Potential side effects of vaccines discussed		Y/N
PIL from packaging of vaccines given to patient		Y/N
Post vaccination advice leaflet given		Y/N
Vaccine details recorded on patient computer record (vaccine name, batch no, site etc)		Y/N
SMS vaccine reminder service set up		Y/N
Travel record supplied		Y/N

Signed by:_____ **Date** _____