**TRAVEL RISK ASSESSMENT FORM** – ideally to be completed by traveller prior to appointment.

|  |  |
| --- | --- |
| Name: | Date of birth |
| Male □ Female □ |
| E mail: | Telephone number:Mobile number: |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW** |
| Date of departure: | Total length of trip: |
| **COUNTRY TO BE VISITED** | **EXACT LOCATION OR REGION** | **CITY OR RURAL** | **LENGTH OF STAY** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| Have you taken out travel insurance for this trip? Do you plan to travel abroad again in the future? |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY** |
| □ Holiday □ Staying in hotel □ Backpacking Additional information□ Business trip □ Cruise ship trip □ Camping/hostels□ Expatriate □ Safari □ Adventure□ Volunteer work □ Pilgrimage □ Diving□ Healthcare worker □ Medical tourism □ Visiting friends/family |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** |
|  | **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. yourspleen 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) complaints |  |  |  |
| Liver and or kidney problems |  |  |  |
| HIV/AIDS |  |  |  |
| Immune system condition |  |  |  |

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|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| 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 undergone FGM / been cut / circumcised |  |  |  |

**Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)?

|  |
| --- |
| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** |
| Tetanus/polio/diphtheria |  | MMR |  | Influenza |  |
| Typhoid |  | Hepatitis A |  | Pneumococcal |  |
| Cholera |  | Hepatitis B |  | Meningitis |  |
| Rabies |  | JapaneseEncephalitis |  | Tick BorneEncephalitis |  |
| Yellow fever |  | BCG |  | Other |
| Malaria Tablets |

|  |
| --- |
| Smoking info: Smoking does increase the risks of circulatory problems, If you would like to stop smoking Quit Ready offers free and confidential text, phone and web chat advice for more details please call 0345 646 66 66 or visit [www.quitready.co.uk](http://www.quitready.co.uk)Do you smoke? □ Ex-smoker □ Never smoked □ Smoker ………. per dayRead code for office use only: 8CAL |

|  |  |
| --- | --- |
| Date form received: | Taken by: |

**Please note:**

**We have only limited availability for this service – Patients who will be travelling within 4 weeks may not be able to have an appointment before they travel**

**To ensure that your health is fully covered before your holiday please complete and return this form to the surgery at least 8 weeks before you travel.**

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel*

*Health Medicine*. RCN, London. [www.rcn.org.uk](http://www.rcn.org.uk/)

2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.

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