**TRAVEL RISK ASSESSMENT FORM**

# **To help plan your travel vaccinations you must complete and hand this form in AT LEAST SIX (6) TO EIGHT (8) WEEKS PRIOR TO DEPARTURE or else it will not be possible to give you an appointment at Mountwood Surgery, and you will have to seek an alternative travel clinic.**

Some vaccines need to be given well in advance to allow your body to develop immunity, whilst some vaccines involve a number of doses spread over several weeks or months.

# **Which travel vaccines are free?**

The following travel vaccines are available free on the NHS from your GP surgery:

* polio (given as a combined diphtheria/tetanus/polio jab)
* typhoid
* hepatitis A
* cholera

These vaccines are free because they protect against diseases thought to represent the greatest risk to public health if they were brought into the country.

Not all travel vaccines are provided on the NHS. The cost of such travel vaccines will vary, depending on the vaccine and number of doses you need. It's worth considering this when budgeting for your trip.

# **Next Steps**

An initial assessment of the Travel Risk Assessment Form will be undertaken by our practice nurses, and based upon the information provided in this application form, will advise the patient(s) regarding the need for specific travel requirements and/or request a face-to-face assessment with the patient.

Due to pressures on clinician workload there are limited appointments available for travel vaccinations. These have to be some weeks before departure. Malaria prescriptions are not prescribed.

Please follow this link [https://www.fitfortravel.nhs.uk/home](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.fitfortravel.nhs.uk%2Fhome&data=05%7C02%7Cc.bateman6%40nhs.net%7C7a5673183d5a4cb0a0fd08dce6d87584%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638639064561327182%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=5IAammpQq%2FbO1yT5mQ5%2B48xxqLxkze9cmuTLcVF4JV4%3D&reserved=0)

**Date completed and handed into Reception: ……………………………………………...**

**TRAVEL RISK ASSESSMENT FORM (to be completed by traveller prior to appointment).**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | Date of birth: | | | | | |
| Male □ Female □ Non-binary □ | | | | | |
| Email: | | 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. |  | | | |  | |  |
| What modes of transport will you be using?  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. 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) complaints | | |  |  | |  | |
| Liver and or kidney problems | | |  |  | |  | |
| HIV/AIDS | | |  |  | |  | |
| Immune system condition | | |  |  | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **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 |  | Japanese encephalitis |  | Tick borne encephalitis |  |
| Yellow fever |  | BCG |  | Other | |
| COVID-19 (dates, brand etc.) | | | | | |
| Malaria Tablets | | | | | |

**Any additional information**