**TRAVEL RISK ASSESSMENT FORM** – please complete and email to nhccg.cghpartnership@nhs.net

You will be contacted with an appointment within 2 weeks

|  |  |
| --- | --- |
| Name: | Your country of origin: |
| 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 |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| Mental health issues (including anxiety, depression) |  |  |  |
| Neurological (nervous system) illness |  |  |  |
| Respiratory (lung) disease |  |  |  |
| Rheumatology (joint) conditions |  |  |  |
| Any other conditions? |  |  |  |
| **Women only** |
| Are you pregnant or planning pregnancy? |  |  |  |
| Are you breastfeeding? |  |  |  |
| Have you undergone FGM / been cut / circumcised |  |  |  |

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

**Any additional information i.e. previous vaccinations (if known)**

**\*\*\* To be completed by the Nurse \*\*\***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **VACCINE** | **HAD PREVIOUSLY? (State dates)** | **REQUIRED (Please state vaccine name)** | **TO BE GIVEN AT SURGERY** | **SIGNPOSTED PRIVATELY** | **ADDITIONAL INFORMATION** |
| Diptheria/Tetanus/Polio |  |  |  |  |  |
| Hepatitis A |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |
| Typhoid |  |  |  |  |  |
| Rabies |  |  |  |  |  |
| Yellow Fever |  |  |  |  |  |
| Other (please state) |  |  |  |  |  |
| Malaria Prophylaxis |  |  |  |  |  |