**TRAVEL RISK ASSESSMENT FORM** – please complete and email to [nhccg.cghpartnership@nhs.net](mailto: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. 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 |  |  |  |
| 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 |  |  |  |  |  |