GARFORTH MEDICAL PRACTICE
TRAVEL RISK ASSESSMENT FORM

Please complete this form and hand in at reception as soon as possible. If your date of travel is within the next 2-3 weeks we may not have the capacity to provide travel advice and immunisations.

Personal details	
Name:	Date of birth:
Daytime contact telephone number:	
Dates of trip	
Date of departure	
Return date or overall length of trip	

Itinerary and purpose of visit		
Country to be visited	Length of stay	Away from medical help at destination, if so, how remote?
1.		
2.		
3.		

Please tick as appropriate below to best describe your trip						
1. Type of trip	Business		Pleasure		Other	
2. Holiday type	Package		Self organised		Backpacking	
	Camping		Cruise ship		Trekking	
3. Accommodation	Hotel		Relatives/family home		Other	
4. Travelling	Alone		With family/friend		In a group	
5. Staying in area which is	Urban		Rural		Altitude	
6. Planned activities	Safari		Adventure		Other	

Personal medical history (Please delete as appropriate)
Do you have any allergies for example to eggs, antibiotics, nuts? YES / NO If yes please give details:
Have you ever had a serious reaction to a vaccine given to you before? YES / NO
Does having an injection make you feel faint? YES / NO
Do you or any close family members have epilepsy? YES / NO
Do you have any history or mental illness including depression or anxiety? YES / NO
Have you recently undergone radiotherapy, chemotherapy or steroid treatment? YES / NO
Women only: Are you pregnant or planning pregnancy or breastfeeding? YES / NO
Have you taken out travel insurance? YES / NO

Vaccination history					
Have you ever had any of the following vaccinations / malaria tablets and if so when?					
Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
Pneumonia		Other			
Malaria Tablets					

A practice nurse will confirm the receipt of the form within 10 working days and will give an idea of when an assessment will be made to determine when or if a travel consultation is required.

Below to be completed at travel consultation if required.

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed:……………………………………….. Date:……………………………

Print Name:…………………………………..

INITIAL RISK ASSESSMENT FOR OFFICIAL USE			
Patient Name:			
Initial Travel risk assessment performed by:-			
Travel vaccines recommended for this trip by NATHNAC			
Disease protection	Yes	No	Further information eg. Up to date immunisations.
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

Recommended malaria chemoprophylaxis			
Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline			