Llandrindod Wells Medical Practice

Travel Risk Assessment Form – to be completed by patient prior to appointment

Name:		Da	te of birth				
E-mail:		N/a	ulo.		Female		
E-mail:		IVIC	Male Female				
Telephone Number:		Мо	Mobile Number:				
PLEASE	SUPPLY INFORMATION	I ABOUT	YOUR TRIE	P IN THE	SECTIONS BELOW	/	
Country to be visited	Exact Location or reg		City or R		Date of travel	Length of stay	
1.							
2.							
۷.							
3.							
Have you taken out travel in	nsurance for this trip?						
Do you plan to travel abroa	d again in the future?						
ТҮРЕ	OF TRAVEL AND PURPO	OSE OF TE	RIP – PLEA	SE TICK	ALL THAT APPLY		
Holiday	Staying in hotel	Backpa	cking		ADDITI	ONAL INFO	
	Cruise ship trip Camping/h			_			
Expatriate	Safari	Advent	ure				
Volunteer Work	Pilgrimage	Diving					
Healthcare Work	Medical Tourism	Visiting	friends/f	amily			
		05.40110	DEDCOM				
ν.	LEASE SUPPLY DETAILS	OF YOUR		•			
			YES	NO	Details		
Are you fit and well today	•						
Any allergies including fo							
Severe reaction to a vacc							
Tendency to faint with inject							
Any surgical operations in t	he past, including e.g. y	our splee	n				
or thymus gland removed	ath and an /anaa a tuan an l						
Recent chemotherapy/radio	otnerapy/organ transpi	ant					
Anaemia Bleeding / clotting disorder	s (inc. history of DV/T)						
Heart disease (e.g. angina,	<u> </u>						
Diabetes	mon blood pressure						
Disability							
Epilepsy/seizures							
Gastrointestinal (stomach)	complaints						

Your information will be processed confidentially, securely and in accordance with the General Data Protection Regulation (GDPR).

NURSE:			
APPOINTMENT DATE & TIN	VIE:		
ADDOINTS ASSESSED STORY	145		
EMIS NUMBER:			
OFFICE USE ONLY			
The state of the s			
Any additional information			
Yellow fever Malaria tablets	BCG	Other	
Rabies	Japanese Encephalitis	Tick Bourne Encephalitis	
Cholera	Hep B	Meningitis	
Typhoid	Нер А	Pneumococcal	
Tetanus/polio/diphtheria	MMR	Influenza	
		ES OR MALARIA TABLETS IN THE PAS	ST
Are you pregnant Are you breastfeeding Are you planning pregnancy we have you undergone FGM / b	een cut / circumcised	purchased or contraceptive pill)?	
WOMEN ONLY			
Any other conditions			
Spleen problems			
Rheumatology (joint) condition	ons		
Respiratory (lung) disease	.,		
Mental Health (inc. anxiety, d Neurological (nervous system			
Immune system condition	lonrossion)		
HIV/AIDS			
Liver or kidney problems			

Created by Llandrindod Wells Medical Practice 2017

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