TRAVEL RISK ASSESSMENT FORM

MUST be completed by traveller prior to phone appointment

Please return this form 12 weeks prior to travel

Name:	Your country of origin:
	Date of birth:
	Male □ Female □ Other □
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
☐ Business trip	☐ Cruise ship trip	☐ Camping/hostels
☐ Expatriate	☐ Safari	☐ Adventure
☐ Volunteer work	☐ Pilgrimage	☐ Diving
☐ Healthcare worker	☐ Medical tourism	☐ Visiting friends/family

☐ Additional information

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			
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	
Malaria Tablets					

Any additional information

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in TravelHealth Medicine*. RCN, London.
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.
3. Form devised and created by Jane Chiodini © updated 2018

Compass House
Medical Centres

All correspondence to: King Street Brixham, Devon, TQ5 9TF
Branch site: 2 Langdon Lane, Galmpton, Devon, TQ5 0PG

Third-Party Consent for Travel Risk Assessment

If a patient aged 12 years or over wishes to nominate a family member/ representative to discuss their completed Travel Risk Assessment Form on their behalf, please complete, sign, and date the consent form below.

This will provide consent for the nurse to discuss travel vaccinations for this appointment.

If this form is not completed, the nurse will be unable to process the request.

Patient's Name:	
Name of person authorised to act on the patient's behalf: (Full Name)	
Relationship to Patient:	
Patient's Signature:	
Date:	