

TINKERS LANE SURGERY TRAVEL RISK ASSESSMENT FORM

Please **BOOK AN APPOINTMENT** with a nurse upon collecting this form. Our nurse can then cancel your appointment if your vaccines are all up-to-date and you do not need travel advice, or if we are unable to supply the vaccines you need.

Please complete this form **6-8 weeks before travel**, and please hand it on prior to your appointment.

We are ONLY doing NHS funded vaccines, you will need to attend a private clinic for non-NHS vaccines: Rabies, Hepatitis B, Tick, Japanese encephalitis, Meningitis and Yellow fever [please see surgery travel leaflet for alternative centres.

Name:		Age:	
Date of Birth:		Gender:	
Telephone Number:			
If for any reason we are unable to contact you, can we leave a message with a relative? YES/NO			
If yes, who and which number is best:		Name:	
		Number:	
Trip dates:	Departure:	Return:	
Length of Trip:			
Purpose of visit:			
Itinerary:			
Country/City or Area		Length of stay: [in each country/City/Area]	
1			
2			
3			
Are you staying somewhere remote, away from medical help?			YES NO
If yes, where?			
Trip Description:		PLEASE CIRCLE YOUR ANSWERS BELOW.	
Business		Leisure Other	
Holiday Type:		Package Self-organised Volunteer	
Backpacking		Camping/Glamping Cruising	
Trekking		Medical/Surgery Other	
Accommodation:		Hotel Hostel Cruise ship	
		Tent Apartment Family home	
Staying with locals		Eg Families/Friends	
Travelling:		Alone Family/Friends Organised Group	
Area:		Urban Rural High Altitude	
Planned or possible Activities:		Safari Climbing/Scuba diving Voluntary work	
Helping Animals		Tattoo's Dentist/Surgery Other	

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Do you have any recent or past medical history that could affect the choice of vaccines or malaria tablets? If yes, please write below:							
Are you taking any medication not on repeat supplied by a private clinic, hospital, or OTC from chemist If yes, please write these here:							
Do you have any allergies? Eg: Eggs, Antibiotics, medicines, plasters, etc?							
Have you ever had a serious reaction to a vaccine given to you before? E.g.: Anaphylaxis, breathless, chest pain.							
Do you have, or had any of the following conditions, that can affect the immune system if so please circle them:							
Thymus disorder/ Removal	Spleen disorder/ Removal	HIV	Chemotherapy/ Radiotherapy	COPD/Asthma	Newly immunosuppressed		
						YES	NO
Does having an injection make you feel faint?							
Have you ever had a clot or DVT							
Do you have any history of mental illness inc. depression/anxiety?							
Have you recently undergone radiotherapy, chemotherapy, or steroid treatment?							
Do you have a history of epilepsy/fits							
Have you taken out travel insurance ? If you have any previous medical conditions, have you informed the insurance company about this?							
Females Only: Are you pregnant, planning pregnancy or breast feeding?							
Please give any further information that may be relevant including any future travel plans in the next 6 months.							
Have you had any vaccinations not in GP surgery e.g., private clinics/MOD/Work? If so, when and what were they, if not added to your record .							
I give permission for the nurse to check my notes prior to my appointment and ring me or my nominated person for further information if needed.							
Name:				Signed on behalf of patient <input type="checkbox"/>			
Signature:				Date:			