pharmadoctor

Travellers' diarrhoea Risk Assessment Form

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ☐	**D.o.B.:** _ _ / _ _ / _ _	**Age:** ________
Name:	**Home Address:**	
Surname:		
Email:	**Name & Address of GP** (optional)	
Telephone:	Would you like your GP to be informed of this consultation? Yes ☐ No ☐	

Please answer the following questions

Do you have any allergies? *If yes, please describe the allergy/reaction*	Yes ☐ No ☐	Have you had a serious reaction or intolerable side effects to rifaximin, ciprofloxacin or any other medications before? *If yes, please describe the product and the reaction*	Yes ☐ No ☐
Are you pregnant, planning pregnancy or is there a possibility that you could be pregnant?	Yes ☐ No ☐	Are you currently breast-feeding?	Yes ☐ No ☐
Do you have any liver problems? *If yes, please provide details*	Yes ☐ No ☐	Do you have any kidney problems? *If yes, please provide details*	Yes ☐ No ☐

Do you have any of the problems listed below? *If yes, please select the relevant option below*			Yes ☐ No ☐
Reduced heart function	☐	Low levels of potassium or magnesium in your blood	☐
Slow or irregular heart beat	☐	Prolonged QT interval	☐
Other heart problem (please provide details)			

Have you been told by your doctor that you have an intolerance to any sugars? *If yes, please provide details*	Yes ☐ No ☐	Have you had a high fever or temperature in the last 24 hours? *If yes, please provide the cause and length of fever*	Yes ☐ No ☐
Do you weigh less than 45kg (7 stone, 1 lb)?	Yes ☐ No ☐	Do you have diabetes?	Yes ☐ No ☐
Do you have constipation, abdominal pain or vomiting caused by blockage of the bowel?	Yes ☐ No ☐	Do you have epilepsy or any other neurological problems?	Yes ☐ No ☐
Do you suffer from myasthenia gravis?	Yes ☐ No ☐	Do you have any stomach problems or inflammatory bowel disease?	Yes ☐ No ☐

Have you ever suffered/do you currently suffer from any of the conditions listed below? *Please answer yes even if the episode was mild or an isolated case*			Yes ☐ No ☐
Anxiety	☐	Panic attacks	☐
Depression	☐	Any other mental, emotional or behavioural problems (please provide details below)	☐
Details:			

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Please answer the following questions
Please provide details of any recent or past medical history of note (e.g. other medical conditions you have previously been treated for)
Please list all your current prescription medication including any medication you buy over the counter
Please list all countries that you are going to visit

Country to be visited	Arrival date	Departure date

Please select the reason for travel

Business	☐	Pleasure	☐	Hajj or other pilgrimage	☐	Visiting friends or relatives	☐
Other (please specify)	☐						

Please select the accommodation you are staying in

Hotel	☐	Camping	☐	Other (please specify)	☐	

Please provide any other trip details you feel we should know

Do you want to complete a consultation for travellers' diarrhoea medication only? Yes ☐ No ☐
It is recommended that patients receive a full travel consultation

If yes, do you understand that you may be exposed to other diseases and health risks on which this consultation will not advise? Yes ☐ No ☐

PATIENT CONSENT

I have received information on the risks and benefits of the treatment and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the treatment being given.

Signature of patient____________________________________ **Date** _______________________________________

HEALTHCARE PROFESSIONAL USE ONLY

Non-supply/administration

I confirm that the patient did NOT receive the medication ☐	Patient referred to GP ☐
Reason for non-supply/administration	

Supply/administration

I confirm that the patient is not contraindicated based on the information provided by the PGD	☐
I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur	☐
I have provided the patient with an information leaflet (PIL) for the treatment I am supplying, and advised them to read it	☐

Healthcare Professional Name	Healthcare Professional Signature