**Travel *Consultation risk assessment form ***

Patient Travel Consultation Details

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| Title: |       | Gender: |       |  | Address: |       |
| First Name: |       |
| Surname: |       | City: |       |
| Date of Birth: |       | Postcode: |       |
| Telephone: |       | Country: |       |
| Mobile: |       | Email: |       |
| GP Name and Address:       Would you like your GP to be notified of this consultation? |  | [ ]  |  |

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| **Vaccine history** | **Date** |  | **Vaccine history** | **Date** |
|       |       |  |       |       |
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| **Destination country** | **Arrival Date** | **Departure Date** |
|       |       |       |
|       |       |       |
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| **Reason for travel** |
| Hajj or other pilgrimage | [ ]  |  | Visiting friends or relatives | [ ]  |  | Altitude | [ ]  |
| Other *(Please specify)* |       |

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| **Medical information (tick either ‘Yes’ or ‘No’, as appropriate and provide further details where asked.)** |
| Y [ ]  | N [ ]  | **Are you a frequent traveller?** |
| Y [ ]  | N [ ]  | **Are you currently taking any medications (prescription or non-prescription)?** *(if so please give details below)* |
|       |
| Y [ ]  | N [ ]  | **Have you had a high fever or temperature in the last 24 hours?** *(If yes, provide cause & length of fever?)* |
|       |
| Y [ ]  | N [ ]  | Are you taking any regular medication which thins your blood or prevents it from clotting excluding aspirin 75mg? *(If yes, please provide more details)* |
|       |
| Y [ ]  | N [ ]  | Have you had past or recent surgery? *(If yes, please provide more details)* |
|  |  |  |
| Y [ ]  | N [ ]  | Women only: Are you pregnant, planning pregnancy or breast-feeding? *(If yes, please provide more details)* |
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| **Medical information – continued** |
| Y [ ]  | N [ ]  | Are you receiving daily injections to thin your blood? |
| Y [ ]  | N [ ]  | Do you have any ongoing medical problems? (If yes, please select the relevant option below) |
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| --- | --- | --- | --- | --- |
| Diabetes |[ ]   | High blood pressure |[ ]   | Asthma |[ ]
| Epilepsy | ☐ |  | Kidney disease |[ ]   | Liver disease |[ ]
| Sickle cell |[ ]   | Porphyria |[ ]   | Myasthenia gravis |[ ]
| Other (provide details) Click or tap here to enter text. |

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| Y [ ]  | N [ ]  | Do you have any bleeding disorders? *(If yes, please provide more details)* |
|       |
| Y [ ]  | N [ ]  | Are you receiving dialysis? |
| Y [ ]  | N [ ]  | Have you been told you may have low immunity? *(If yes, please select the relevant option below)* |
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| Had solid organ / bone marrow / stem cell transplant |[ ]   | Have HIV |[ ]
| Received chemotherapy or radio therapy in last 6 months |[ ]   | Are immunocompromised |[ ]
| Taken immunosuppressant in last 6 months |[ ]   | Have had your spleen removed |[ ]
| Are currently or have taken steroids in the last month |[ ]   | On dialysis |[ ]
| None of the above |[ ]   |  |  |

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| Y [ ]  | N [ ]  | Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine? |
| Y [ ]  | N [ ]  | Have you had any allergies or severe reactions to previous vaccinations? (*If yes, list the vaccines)* |
|       |
| Y [ ]  | N [ ]  | Do you have any allergies (*e.g eggs, antibiotics, nuts, medications*)? |
|       |
| Y [ ]  | N [ ]  | Do you suffer from thymus dysfunction? *(If yes, please provide more details)* |
|       |
| Y [ ]  | N [ ]  | Have you had your school leavers DTP vaccine? *(If yes or unsure, please provide details)* |
|       |
| Y [ ]  | N [ ]  | Do you have any cerebral disorders *(e.g. Epilepsy or Stroke)? (If yes, please provide more details)* |
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| Y [ ]  | N [ ]  | Have you ever take antimalarials before? (If yes, select all the antimalarial you have taken before.) |
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| Mefloquine |[ ]  Doxycycline |[ ]  Atovaquone/Proguanil |[ ]  Chloroquine |[ ]  Proguanil |[ ]  unsure |[ ]

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| Y [ ]  | N [ ]  | Have you have ever had problems taking any malaria medication before? *(If yes, please provide details)* |
| Y [ ]  | N [ ]  | Have you had a serious liver problem requiring a liver specialist review? *(If yes, please provide details)* |
|       |
| Y [ ]  | N [ ]  | Have you had any serious kidney problem with your kidney requiring a kidney specialist review?*(If yes, please provide full history of your kidney condition & any interventions of your kidney condition)* |
|       |
| Y [ ]  | N [ ]  | Have you had kidney failure due to malaria or Blackwater fever? *(If yes, please provide details)* |
|       |
| Y [ ]  | N [ ]  | Do you or any close family suffer from epilepsy? |
| Y [ ]  | N [ ]  | Have you ever suffered/do you currently suffer from?*(Please answer yes even if the episode was mild or an isolated case, If yes identify below)* |
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| Anxiety |[ ]   | Panic attacks |[ ]   | Depression |[ ]
| Any other psychiatric problems      |

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| Y [ ]  | N [ ]  | Are there any other health/medical details you feel we should know? (If yes, please provide details using the full name of the condition(s) enter below)  |
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| **FOR OFFICIAL USE ONLY** |
| **Further advice/documentation provided** |
| Water and personal hygiene |  | Travellers' diarrhoea |  | Hepatitis B and HIV |  | Leaflets given including PILs |  |
| Insect bite prevention |  | Animal bites |  | Accident avoidance |  | Meningitis (ACWY) certificate given |  |
| Insurance |  | Air travel |  | Sun and heat protection |  | Yellow Fever certificate given |  |

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| **Malaria Oral Medicine** | **Date** | **Quantity** | **Details** | **Price** |
| Atovaquone + Proguanil |  |  |  |  |
| Lariam (mefloquine) |  |  |  |  |
| Doxycycline |  |  |  |  |
| Paludrine (chloroquine + proguanil) |  |  |  |  |
| Chloroquine |  |  |  |  |

For each vaccine add: Date, batch No, expiry date and administration site

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| --- | --- | --- | --- | --- |
| **Vaccine** | **Consultation 1** | **Consultation 2** | **Consultation 3** | **Price** |
| Yellow fever |  |  |  |  |
| Meningitis ACWY |  |  |  |  |
| Typhoid |  |  |  |  |
| Combined Hep A + Typhoid |  |  |  |  |
| Combined Hep A + Hep B |  |  |  |  |
| Hep A |  |  |  |  |
| Hep B |  |  |  |  |
| Tick-borne encephalitis |  |  |  |  |
| Japanese encephalitis |  |  |  |  |
| Rabies |  |  |  |  |
| Cholera |  |  |  |  |
| Mefloquine |  |  |  |  |
| Doxycycline |  |  |  |  |
| Atovaquone/ proguanil |  |  |  |  |
| Dip / Tet / Polio |  |  |  |  |

**PATIENT CONSENT**

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions.

**I consent to the recommended medicines being given at EACH APPOINTMENT.**

Patient / Guardian signature...     ............................ /.................... ................. /................................. Date.......     ......................

Pharmacist's signature....................... ................../.................... ................ /.................................. Date.............................

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? **Yes / No**