Border Practice Travel Vaccination Risk Assessment Form

Please complete the following form and send to the surgery or hand to a receptionist, at least 4 WEEKS before your planned travel date.

The Practice Nurse will review the risk assessment and be in contact regards vaccines required.

Some vaccines may be chargeable.

Travel Health resources: www.travelhealthpro.org.uk or https://www.fitfortravel.nhs.uk

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

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			

	YES	NO	DETAILS
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

Please return this form to The Border Practice, Blackwater Way, Aldershot, Hampshire, GU12 4DN

Office Use Only:

GP to sign. _____

GP Name _____

Date _____

I authorise the practice nursing staff to administer a vaccine or course of any of the above vaccines which are not covered by North East Hampshire & Farnham CCG patient group directions.

Signature _____