

THE THREE SHIRES MEDICAL PRACTICE

Colerne, Marshfield, Pucklechurch and Wick Surgeries

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TRAVEL ASSESSMENT FORM

Please complete this form prior to your travel appointment and return to reception

Personal details			
First Name:	Surname:	Date of birth:	
		Male [] Female []	
Easiest contact telephone number			
Dates of trip			
Date of Departure			
Return date or overall length of trip			
Itinerary and purpose of visit			
Country to be visited	Length of stay	Away from medical help at destination, if so, how remote?	
1.			
2.			
3.			
Please tick as appropriate below to best describe your trip			
1. Type of trip	Business	Pleasure	Other
2. Holiday type	Package	Self organised	Backpacking
	Camping	Cruise ship	Trekking
3. Accommodation	Hotel	Relatives / family home	Other
4. Travelling	Alone	With family / friend	In a group
5. Staying in area which is	Urban	Rural	Altitude
6. Planned activities	Safari	Adventure	Other
Personal medical history			
Please list any regular "over the counter" medication you take, that are not on you records here:			
Have you ever had a serious reaction to a vaccine given to you before?			
Does having an injection make you feel faint?			
Do you have any history or mental illness including depression or anxiety			
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?			
<i>Women only:</i> Are you pregnant or planning pregnancy or breast feeding?			
Please write below any further information which may be relevant			
P.T.O.			

Vaccination History							
Have you ever had any of the following vaccinations that would not be on your GP records (e.g from Travel Clinics / Abroad? Please give dates							
Tetanus		Polio		Diphtheria		Typhoid	
Hepatitis A		Hepatitis B		Meningitis		Yellow Fever	
Rabies		Jap B Enceph		Tick Borne			
TB (BCG)		Other					

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed _____ Date _____

For official use			
Patient Name:			
TRAVEL VACCINES RECOMMENDED FOR THIS TRIP			
Disease protection	Yes	Further information	
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Rabies			
Japanese B Encephalitis			
Yellow Fever			
TB (BCG)			
	Yellow Fever Vaccination available from : Box Surgery (01225 742361), Bath Travel – Sat 8-2pm (01225 820461), Courtside Surgery (01454 313874 or Christchurch Medical Centre, North St, Downend (0845 6580744)		
Other			
TRAVEL ADVICE AND LEAFLETS GIVEN AS PER TRAVEL PROTOCOL			
Travel advice leaflet given		Comments	
Travel Record card supplied			
MALARIA PREVENTION ADVICE and MALARIA CHEMOPROPHYLAXIS			
Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	
Private Prescription Required or		Dispense Tablets at Surgery	
FUTHER INFORMATION e.g. weight of child		Malaria Tabs:	Private Rx / Dispense Done(sig):
Signed by: Nurse	Date:	GP:	Date: Scanned by: