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TRAVEL RISK ASSESSMENT FORM(to be completed by traveller prior to appointment)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name:  Address: | | Your country of origin: | | | | | |
| Date of birth: | | | | | |
| Age: Weight: | | | | | |
| E mail: | | Telephone/Mobile number:  Emergency Contact Name and 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. |  | | | |  | |  |
| What modes of transport will you be using?  Have you taken out travel insurance for this trip?  Do you plan to travel abroad again in the future?  Visiting Friends and Family? | | | | | | | |
| **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? | | |  |  | |  | |
| Have you, or anyone in your family, had a severe reaction to a vaccine or malaria medication before? | | |  |  | |  | |
| Any other vaccines in the last 1 month? | | |  |  | |  | |
| Tendency to faint with injections? | | |  |  | |  | |
| Any surgical operations in the past, including e.g. open heart surgery, spleen or thymus gland removal? | | |  |  | |  | |
| Recent chemotherapy/radiotherapy/organ transplant? | | |  |  | |  | |
| Anaemia? | | |  |  | |  | |
| Bleeding /clotting disorders (including history of DVT) or on blood thinners? | | |  |  | |  | |
| Heart disease (e.g. angina, high blood pressure)? | | |  |  | |  | |
| Diabetes? | | |  |  | |  | |
| Additional needs and/or disability? | | |  |  | |  | |
| Epilepsy/seizures (or in a first degree relative?) | | |  |  | |  | |
| Gastrointestinal (stomach) complaints? | | |  |  | |  | |
| Liver and or kidney problems? | | |  |  | |  | |
| HIV/AIDS? | | |  |  | |  | |
|  | | |  |  | |  | |

|  |
| --- |
| * **Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)? |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| Immune system condition e.g. blood cancer? |  |  |  |
| Mental health issues (including anxiety, depression)? |  |  |  |
| Neurological (nervous system) illness? |  |  |  |
| Respiratory (lung) disease? |  |  |  |
| Rheumatology (joint) conditions? |  |  |  |
| Spleen problems? |  |  |  |
| Any other conditions? |  |  |  |
| Are you or your partner pregnant or planning a pregnancy? |  |  |  |
| Are you breast feeding (if applicable) ? |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 | |
| COVID-19 (dates, brand etc.) | | | | | |
| Malaria Tablets | | | | | |

Signed by Patient (or Parent/Guardian) ……………………………… Date ………………

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel* *Health Medicine*. RCN, London.
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.