**Date Received:**

**BURTON LATIMER MEDICAL CENTRE**

**TRAVEL FORM**

If you are travelling abroad and you require advise/vaccinations please make an appointment in our treatment room after completing and handing in this form.

These appointments can be booked by our receptionists. The earlier you attend prior to your travel dates the better. Please be aware that you may attend for appointment and not require any vaccinations but the nurse may give you some useful up-to-date travel advice

If you require vaccinations close to your departure, have a complex itinerary, require a Yellow Fever vaccination, need a vaccination that the NHS does not routinely provide or are struggling to attend the GP surgery for an appointment your local MASTA travel clinic is a Private Travel Health Provider that may be able to help you. Telephone number: 0330 1004200 or www.masta-travel-health.com

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| **Personal details** |
| Name: | Date of birthMale ( ) 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. |  |  |
| Future travel plans |  |  |
| **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** |
| Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions) |
| List any current or repeat medications |
| Do you have any allergies for example to eggs, antibiotics, nuts? |
| Have you ever had a serious reaction to a vaccine given to you before? |
| Does having an injection make you feel faint? |
| Do you or any close family members have epilepsy? |
| Do you have any history or mental illness including depression of anxiety? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |
| ***Women only:*** Are you pregnant or planning pregnancy or breast feeding? |
| Have you taken out travel insurance if you have a medical condition, informed the insurance company about this? |
| Please write below any further information which may be relevant |

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| Vaccination history |
| Have you ever had any of the following vaccinations/malaria tablets and if so when? |
| Tetanus |  | Polio |  | Diphtheria |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | Tick Borne |  |
| Other |
| Malaria tablets |

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:

***To be completed by Practice Nurse***

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| Appointment time needed: | Patient phoned: |

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| **FOR OFFICAL USE** |
| Patient Name: |
| Travel Risk assessment performed Yes ( ) No ( ) |
| **Travel vaccines recommended for this trip** |
| Disease protection | Yes | No | Further information |
| Hepatitis A |  |  |  |
| Hepatitis B |  |  |  |
| Typhoid |  |  |  |
| Cholera |  |  |  |
| Tetanus |  |  |  |
| Diphtheria |  |  |  |
| Polio |  |  |  |
| Meningitis ACWY |  |  |  |
| Yellow Fever |  |  |  |
| Rabies |  |  |  |
| Japanese B Encephalitis |  |  |  |
| Other |  |  |  |

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| **Travel advice and leaflets given as per travel protocol** |
| Food water and personal hygiene advice  |  | Travellers’ diarrhoea |  | Hepatitis B and HIV |  |
| Insect bite prevention |  | Animal bites |  | Accidents |  |
| Insurance |  | Air travel |  | Sun and heat protection |  |
| Websites | Travel Record card supplied |
| Other |

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| **Malaria prevent advice and malaria chemoprophylaxis** |
| Chloroquine and proguanil |  | Atovaquone + proguanil (Malarone) |  |
| Chloroquine |  | Mefloquine |  |
| Doxycycline |  | Malaria advice leaflet given |  |

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| **Further information** |
| e.g. weight of child |

Signed by: Position: Date: |

**Now scan this form into the patient’s record on the computer for evidence of best practice.**

Date Reviewed September2021