**Date Received:**

**BURTON LATIMER MEDICAL CENTRE**

**Travel Questionnaire**

Please complete this form andreturn it to the surgery. We will then check what vaccinations are recommended for the countries you are visiting. Some vaccination courses can take up to 6 weeks to be fully effective so please give us as much notice as possible.

***WE REQUEST YOU COMPLETE OUR QUESTIONNAIRE 2 MONTHS BEFORE TRAVEL****. Please complete the form as fully as possible to help us give you individual advice specific to your destination and reason for travel.*

If you are planning a complicated itinerary (from a travel point of view) we suggest you complete the questionnaire as early as possible to allow time for full courses of vaccine to be given. Some vaccines are not routinely available on the NHS.

Your local independent Masta Travel Centre telephone number is : 01908 619901. The clinic is open most weekdays and can provide early morning or evening appointments, usually with a couple of days notice. They provide a full range of travel vaccinations and malaria prophylaxis, which we keep in stock and retail items including insect repellent, first aid kits and mosquito nets.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal details** | | | | | | | | | |
| Name: | | | | | 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. | |  | | | |  | | | |
| 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 | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Appointment time needed: | Patient phoned: |  |  |  |  |  | | --- | --- | --- | --- | | **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 |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **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 | | | |  |  |  |  |  | | --- | --- | --- | --- | | **Malaria prevent advice and malaria chemoprophylaxis** | | | | | Chloroquine and proguanil |  | Atovaquone + proguanil (Malarone) |  | | Chloroquine |  | Mefloquine |  | | Doxycycline |  | Malaria advice leaflet given |  |  |  | | --- | | **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.**

\\Emis1185a\mswdocs\Practice Nurse Folder\Forms\Travel Clinic.rtf August 2010