**THE LIMES MEDICAL CENTRE**

**TRAVEL RISK ASSESSMENT FORM

(TO BE COMPLETED AND RETURNED TO THE PRACTICE
6-8 WEEKS BEFORE YOU TRAVEL)**

|  |  |
| --- | --- |
| Name: | Date of Birth: |
| Male Female  |
| Email:**Be aware travel advice email may go to junk folder.** | Telephone number:Mobile number: |
| **Please provide a working, current email address as this will be the first point of contact.** |
| **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? |  |  |  |
|  | **YES** | **NO** | **DETAILS** |
| Recent chemotherapy/radiotherapy/organ transplant? |  |  |  |
| 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? |  |  |  |

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| **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 |

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| **Any additional information** |

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

1. Chiodini J, Boyne LO, Grieve S, Jordan A. (2007) Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine. RCM, London. [www.rcn.org.uk](http://www.rcn.org.uk)
2. Field VK, Ford L, Hill DR, eds. (2010) Health Information for Overseas Travel. National Travel Health Network and Centre, London, UK. [www.nathnac.org](http://www.nathnac.org)

Form devised and created by Jane Chiodini © March 2012