

Woodhead Medical Practice

Travel Form

Due to increased demand for travel advice, these forms can take up to 6 weeks to be processed. If you are travelling sooner than this you may need to use a commercial Travel Clinic service.

Personal Details				
Name :	Date of Birth : __ / __ / ____	Male ()	Female ()	
Telephone Number :	Email Address :			
Dates of trip				
Date of departure : __ / __ / ____	Return date OR overall length of trip (days) :			
Details about destination(s)				
Country <u>and</u> location to be visited	Length of stay (days)	Away from medical help at destination? If so, how remote?		
1.				
2.				
3.				
Do you plan to travel abroad in the future? YES / NO				
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 home	Other	
4. Travelling	Alone	With Family / Friend(s)	In a group	
5. Staying in area which is	Urban	Rural	Altitude	
6. Planned activities	Safari	Adventure	Other	
Personal Medical History			Yes	No
Do you have any recent past medical history of note? (including diabetes, heart, lung or spleen conditions)				
Do you have any allergies, for example to eggs, antibiotics, nuts or latex?				
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 of mental illness? (including depression or anxiety)				
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?				
Women only : Are you pregnant or planning pregnancy or breastfeeding?				
Have you taken out travel insurance and if you have a medical condition, informed the insurance company?				
List any current or repeat medications :				
Please write out 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		Polo		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 : _____

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Patient Name : _____

Travel risk assessment performed YES () NO ()

Travel vaccines recommended for this trip

Disease protection	Yes	No	Patient Declined Vaccination	Vaccine name, dose & schedule for PSD
Hepatitis A				
Hepatitis B				
Typhoid				
Cholera				
Tetanus				
Diphtheria				
Polio				
Meningitis ACWY				
Yellow Fever				
Rabies				
Japanese B Encephalitis				
MMR				
Other				

Travel advice and leaflets given as per travel protocol

Food, water & personal hygiene advice		Travellers' diarrhoea		Accidents	
Blood & bodily fluid infection risks (e.g. Hep B)		Animal bites		Sun and heat protection	
Insect bite prevention		Air Travel		Websites	
SMS Vaccines reminder service set up		Insurance		Travel record card supplied	

Malaria prevention advice and malaria chemoprophylaxis

Chloroquine and proguanil		Atovaquone and proguanil	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further Information

[e.g. weight of child]

Authorisation for Patient Specific Direction (PSD) Use

Name : _____ **Signature :** _____ **Date :** _____