**TRAVEL RISK ASSESSMENT FORM** – to be completed by traveller prior to appointment.

|  |  |
| --- | --- |
| Name: | Date of birth |
| Male □ Female □ |
| E mail: | Telephone number: Mobile 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. |  |  |  |
| Will you have access to safe, clean water?Will you be staying in close contact with the local population or in small villages? How far away is medical help? Less than 24 hrs / More than 24hrs (please circle) Have you taken out travel insurance for this trip?  Do you plan to travel abroad again in the future?Have you received and read the attached “Travel Advice Leaflet”?\*\* **If you are travelling to multiple areas please supply your itinerary\*\*** |
| 1. **PURPOSE OF TRIP 2. TYPE OF TRAVEL**
 |
| □ Holiday □ Staying in hotel □ Backpacking □ 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  |  |  |  |
| Are you currently under the care of a consultant |  |  |  |
| 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. yourspleen or thymus gland removed |  |  |  |
| 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  | **YES** | **NO** | **DETAILS** |
| 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/soon after future FUTURE  |  |  |  |
| Have you undergone FGM / been cut / circumcised |  |  |  |

**Are you currently taking any over the counter medication**

 Any additional information

SIGNATURE…………………………………………………………………………………………………………………..

DATE…………………………………………………………………………………………………………………………….

Nurse Completion only

Outcome

SIGNATURE…………………………………………………………………………………………………………………..

DATE…………………………………………………………………………………………………………………………….

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