East Calder & Ratho Medical Practice Travel Form

Personal Details	
Name:	**Date of Birth:**
Contact Tel No:	

Dates:
Date Of Departure:
Return Date or Overall length of trip:

Itinerary and purpose of visit		
Countries to be visited	Length of stay	Away from medical help at destination, if so, how remote?
1.		
2.		
3.		
Any future travel plans?		

Please tick as appropriate below to best describe your trip:													
Type of trip			Business		Pleasure			Other					
Holiday Type	Package		Camping		Self Organised		Cruise Ship		Back packing		Trekking		
Accommodation	Hotel		Relatives/family home				Other						
Travelling	Alone		With family/friend				In a group						
Staying in area which is	Urban		Rural				Altitude						
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 eggs, antibiotic, 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 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		Diptheria	
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_____

FOR OFFICIAL USE

Patient Name:
Travel risk assessment performed : Yes [ ] No [ ]

Travel vaccines recommended for this trip				
Disease protection	**Yes**	**No**	**Patient declined vaccine**	**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		Blood and bodily fluid infection risks eg Hepatitis B	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air Travel		Sun and heat protection	

Websites		SMS vaccines reminder service set up	
Travel record card supplied		Other	

Malaria prevention advice and malaria chemoprophylaxis			
Chloroquine and Proguanil		Atovaquone and Proguanil	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Authorisation for Patient Specific Direction (PSD) Use

Assessor's Name:_____Position:_____ Date_____