

**AMWELL STREET SURGERY
TRAVEL RISK ASSESSMENT QUESTIONNAIRE**



Please complete a form for each member of your party or family.
Please return the completed questionnaire 6 weeks before you travel.

Personal details					
Name:			Date of birth:		
			Male [] Female []		
Daytime telephone number:					
Can a message be left on an answerphone : Yes / No					
E mail					
Dates of trip					
Date of Departure					
Return date or overall length of trip					
Itinerary and purpose of visit					
Country to be visited <i>(please be specific about the area in the country)</i>		Length of stay		Away from medical help at destination, if so, how remote?	
1.					
2.					
3.					
Please tick as appropriate below to best describe your trip					
6. 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

For Office Use Only	Action Taken	PN sent to reception	Tick	Patient telephoned by nurse	Tick
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Personal medical history

(If you are not registered here please obtain a summary of any current; medical conditions, allergies, medication and previous vaccinations you have had from your Doctor)

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 or anxiety:

Have you recently undergone radiotherapy, chemotherapy or steroid treatment:

Women only: Are you pregnant or planning pregnancy or breast feeding?

Please write below any further information which may be relevant

Dr's Name & Address

(please give the details of the surgery you are registered with if not registered here)

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					

I confirm that the above information is correct to the best of my knowledge and request advice about the appropriate vaccinations and tablets for my trip. **I also understand that most travel services are not covered by the NHS and fees will be charged.**

Signed: _____ (parent if under 16) Date: _____

Travel Vaccine Charges

Below are the prices for the different vaccinations that are not covered by the NHS which are available at the surgery.

Vaccination For	Single Dose Cost	Number of Doses Recommended	Cost of Complete Course
Cholera	£12.50	2	£25
Hepatitis B	£40	3	£120
Meningitis A,C,W & Y	£30	1	£40
Rabies	£40	3	£120
Yellow Fever (for Amwell Street patients)	£40	1	£40
Yellow Fever (for Patients not Registered)	£50	1	£50

Payment must be made on the day and can be made by cash or cheque only. Please make cheques payable to:

DR M WENLEY AND PARTNERS

Please note that travel appointments may be difficult to obtain if you book your holiday late. We will always try to accommodate you however, during the spring and summer months this is not always possible.

For official 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 PREVENTION ADVICE and MALARIA CHEMOPROPHYLAXIS

Chloroquine and proguanil	Atovaquone + proguanil (Malarone)
Chloroquine	Mefloquine
Doxycycline	Malaria advice leaflet given

FUTHER INFORMATION

e.g. weight of child

Signed by:

Position:

Date:

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 _____

Now scan this form into the patient's record on the computer