ST ANDREW'S MEDICAL PRACTICE

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Co Durham DL16 6QA
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VAT No: 881190517

Personal details	
Name	Date of birth
Easiest contact number E mail	M ☐ F ☐
Date of trip	
Date of departure	
Return date or overall length of trip	

Details about destination (s)		
Country **and** location to be visited	Length of stay	Away from medical help at destination, if so, how remote?
1.		
2.		
3.		
Return date or overall length of trip		

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					
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	

Personal medical history
Do you have any recent or past medical history of note? (including diabetes, heart or lung condition)
List any current or repeat medication
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 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 breastfeeding?

Have you taken out travel insurance and if you have 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		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
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 informed 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 OFFICE USE		
Patient Name:		
Travel risk assessment preformed	YES	NO

TRAVEL VACCINES RECOMMENDED FOR THIS THRIP				
Disease protection	Yes	No	Patient declined vaccine	Vaccine name, dose & schedule for PSD
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		Traveller' diarrhoea		Bloodand bodily fluid infection risk e.g Hepatitis B	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Websites		SMD vaccines reminder set up			
Travel record car supplied		Other			

MALARIA PREVENTION ADVICE AND MALARIA CHEMOPROPHYLAXIS			
Chloroquine and proguanil		Atovaquone + proguanil	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

FURTHER INFORMATION
e.g. weight of a child

AUTHORISATION FROM PATIENT SPECIFIC DIRECTION (PSD) USE		
NAME:	SIGNATURE:	DATE:

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Please note:
These vaccinations are covered under the NHS service. If any other vaccinations are required the nurse will inform you of the fee during the telephone appointment. This fee will be payable upon arrival for your appointment.

Hepatitis A (1 injection)
Hepatitis A (2 injections)
Typhoid
Hep A and Typhoid
Varicella
Immovax

Men ACWY