**Date form Returned:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal details** | | | | | | | | | |
| Name & address | | | | | Date of Birth:  Male [ ] Female [ ] | | | | |
| Length of appointments when needs to be seen: | | | | |
| Easiest contact telephone number : | | | | | E-mail : | | | | |
| **Dates 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 for more than 24 hours. If so, how remote? | | | |
| 1. | | | |  | |  | | | |
| 2. | | | |  | |  | | | |
| 3. | | | |  | |  | | | |
| Do you plan to travel abroad in the future? | | | | | | | | | |
| **Please tick as appropriate below to best describe your trip** | | | | | | | | | |
| 1.Type of trip | Business |  | Pleasure | | | |  | Other |  |
| 2.Holiday type | Package |  | Self organized | | | |  | 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 |  |
| Personal medical history | | | | | | | | | |
| Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions) | | | | | | | | | |
| List of any current or repeat medications | | | | | | | | | |
| 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? | | | | | | | | | |
| Please write below any further information which maybe relevant: | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Vaccination history** | | | | | | |
| Have you ever had any of the following vaccinations/malaria tablets and if so when: | | | | | | |
| Tetanus | n/c | Polio | | n/c | Diphtheria | n/c |
| Typhoid | n/c | Hepatitis A | | n/c | Hepatitis B x3 | £50 each |
| Meningitis ACWY | £70 | Yellow Fever | | £66 | Influenza | n/c |
| Rabies x3 | £60 each | Cholera | | n/c | Tick Borne x3 | £65 |
| Japanese B encephalitis X 2 £208 (£104 each) | | | Malaria tablets – price on asking | | | |

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| **FOR OFFICIAL USE** |
| Patient Name: See Travel Form 2 Yes/No |
| Travel risk assessment performed Yes [ ] No [ ] |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Travel vaccines recommended for this trip** | | | | |
| Disease protection | Yes | No | Patient declined vaccine | Vaccine name, dose & schedule |
| Hepatitis A |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Typhoid |  |  |  |  |
| Cholera |  |  |  |  |
| Tetanus |  |  |  |  |
| Diphtheria |  |  |  |  |
| Polio |  |  |  |  |
| Meningitis ACWY |  |  |  |  |
| Yellow Fever |  |  |  |  |
| Rabies |  |  |  |  |
| Japanese B Encephalitis |  |  |  |  |
| Other |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Travel advice given as per travel protocol** | | | | | |
| Food, water and personal hygiene advice |  | Traveller’s diarrhoea |  | Blood and bodily fluid infection risks e.g. Hepatitis B |  |
| Insect bite prevention |  | Animal bites |  | Accidents |  |
| Insurance |  | Air travel |  | Sun and heat protection |  |
| Websites e.g fit for travel |  | Travel record card supplied |  | Other |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Malaria prevention advice and malaria chemoprophylaxis** | | | |
| Chloroquine and proguanil |  | Atovaquone and proguanil |  |
| Chloroquine |  | Mefloquine |  |
| Doxycycline |  | Malaria advice leaflet given |  |

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| **Further information** |
| e.g weight of child |

For the most comprehensive up to date travel information, we recommend a visit to [www.fitfortravel.scot.nhs.uk](http://www.fitfortravel.scot.nhs.uk) .

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| **Nurse** |
| Name: Signature: Date: |

**Patient:**- Please ring to book an appointment 2 working days after handing form in.

For discussion when risk assessment is performed within your appointment:

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.

Name: Signature: Date: