**Date form Returned:**

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| **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: |

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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| **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 | £110 each | Cholera | n/c | Tick Borne x3 | £65 |
| Malaria tablets – price on asking | Japanese B Encepahalitis x 2 doses £104 each (subject to availability) |

**Prices are subject to change without notice. To secure the current price, payment is required. By proceeding, you acknowledge that prices may increase and payment locks in the current price.**

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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 | Date of last dose given | Patient declined vaccine | Vaccine name, dose & schedule |
| Hepatitis A |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |
| Typhoid |  |  |  |  |  |
| Cholera |  |  |  |  |  |
| Tetanus |  |  |  |  |  |
| Diphtheria |  |  |  |  |  |
| Polio |  |  |  |  |  |
| Meningitis ACWY |  |  |  |  |  |
| Yellow Fever |  |  |  |  |  |
| Rabies |  |  |  |  |  |
| Other |  |  |  |  |  |

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| **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 |  |

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| **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 |

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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:\_\_\_\_\_\_\_\_\_