

## TRAVEL CONSULTATION FORM

**TO BE FILLED IN BY PATIENT**

**DATE HANDED IN: .....**

|                              |        |                 |
|------------------------------|--------|-----------------|
| Patient Name:                |        | Contact number: |
|                              |        | DOB:            |
| <b>Date of Departure</b>     |        |                 |
| Destination/s                |        |                 |
| Duration                     |        |                 |
| Access to medical facilities | YES/NO |                 |

| Type of trip (tick all that apply)  | Areas to be visited               | Accommodation                      |
|---|-----------------------------------|------------------------------------|
| Package holiday <input type="checkbox"/> Immigration <input type="checkbox"/> Organised adventure trip <input type="checkbox"/> | Urban <input type="checkbox"/>    | Good <input type="checkbox"/>      |
| Cruise <input type="checkbox"/> Backpacking <input type="checkbox"/> Visiting family/friends <input type="checkbox"/>           | Rural <input type="checkbox"/>    | Basic <input type="checkbox"/>     |
| Business <3/12 <input type="checkbox"/> Aid worker <input type="checkbox"/> Elective/Student <input type="checkbox"/>           | Beach <input type="checkbox"/>    | Poor <input type="checkbox"/>      |
| Business >3/12 <input type="checkbox"/> Self-organised <input type="checkbox"/> Voluntary/charity work <input type="checkbox"/> | Altitude <input type="checkbox"/> | Not known <input type="checkbox"/> |

**RECEPTIONIST PLEASE MAKE TELEPHONE APPOINTMENT . APPT DATE AND TIME .....**

**TO BE COMPLETED BY NURSE**

|   |
|---|
| Medical History of Note   |
| Current Medication  |
| Any allergies?  |
| Immunocompromised?  |
| Pregnancy or planning within 3 months returning from trip? YES/NO |
| Previous reaction to vaccination? YES/NO                          |
| Contraindications? YES/NO   |
| Side-effects discussed? YES/NO                                    |

| Recommended vaccines | Had vaccination before? | Required for trip? | Rx Required? |
|----------------------|-------------------------|--------------------|--------------|
|                      |                         |                    |              |
|                      |                         |                    |              |
|                      |                         |                    |              |
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|                      |                         |                    |              |
|                      |                         |                    |              |
|                      |                         |                    |              |
|                      |                         |                    |              |

Malaria Chemoprophylaxis advice given – YES/ N/A    Leaflet given – YES/ N/A    Side effects Yes/ N/A

Tablets recommended

|             |           |             |          |            |                         |
|-------------|-----------|-------------|----------|------------|-------------------------|
| Chloroquine | Proguanil | Doxycycline | Malarone | Mefloquine | Weight (child) kg _____ |
|-------------|-----------|-------------|----------|------------|-------------------------|

| Risks discussed | Yes                      | No                       | PIL                      | Risks discussed    | Yes                      | No                       | PIL                      | Risks discusse      | Yes                      | No                       | PIL                      |
|-----------------|--------------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------------|
| Bite avoidance  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food/water hygiene | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood borne viruses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rabies          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Outbreaks          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sun protection      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____     |                          |                          |                          |                    |                          |                          |                          |                     |                          |                          |                          |

***I have been advised that travel vaccinations aim to minimise risk and not eliminate it and that few vaccines offer 100% protection against disease.***

Signed \_\_\_\_\_

Date \_\_\_\_\_