TRAVEL RISK ASSESSMENT FORM – ideally to be completed by traveller prior to appointment.

Name:	Your country of origin:
	Date of birth:
	Male ☐ Female ☐ Non-binary ☐
E mail:	Telephone number: Mobile number:

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW

Date of departure:	Total length of trip:

COUNTRY TO BE VISITED	EXACT LOCATION OR REGION	CITY OR RURAL	LENGTH OF STAY
1.			
2.			
3.			

What modes of transport will you be using?
Have you taken out travel insurance for this trip?
Do you plan to travel abroad again in the future?

TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY

☐ Holiday	☐ Staying in hotel	☐ Backpacking	Additional information
☐ Business trip	☐ Cruise ship trip	☐ Camping/hostels	
☐ Expatriate	☐ Safari	☐ Adventure	
☐ Volunteer work	☐ Pilgrimage	☐ Diving	
☐ Healthcare worker	☐ Medical tourism	☐ Visiting friends/family	

PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY

	YES	NO	DETAILS
Are you fit and well today			
Any allergies including food, latex, medication			
Have you, or anyone in your family, had a severe reaction to a vaccine or malaria medication before?			
Tendency to faint with injections			
Any surgical operations in the past, including e.g. open-heart surgery, spleen or thymus gland removal?			
Recent chemotherapy/radiotherapy/organ transplant			
Anaemia			
Bleeding /clotting disorders (including history of DVT)			
Heart disease (e.g. angina, high blood pressure)			
Diabetes			
Additional needs and/or disability			
Epilepsy/seizures (or in a first degree relative?)			
Gastrointestinal (stomach) complaints			
Liver and or kidney problems			
HIV/AIDS			

	YES	NO	DETAILS
Immune system condition e.g. blood cancer			
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
Are you or your partner pregnant or planning a pregnancy?			
Are you breast feeding (if applicable)			
Have you or anyone in your family undergone FGM / been cut / circumcised			

Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?

PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST					
Tetanus/polio/diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies		Japanese encephalitis		Tick borne encephalitis	
Yellow fever		BCG		Other	
COVID-19 (dates, brand etc.)					
Malaria Tablets					

Any additional information

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine*. RCN, London.
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.

TRAVEL RISK MANAGEMENT FORM

FOR HEALTH PROFESSIONAL USE ONLY IN CONJUNCTION with TRAVEL RISK ASSESSMENT FORM

Patient Name: **dob:**

Childhood immunisation history checked:

Additional information:

National database consulted for travel vaccines recommended for this trip and malaria chemoprophylaxis (if required): **NaTHNaC:** **Other:**

Disease protection advised	**Yes**	**Disease protection advised**	**Yes**	**Malaria Chemoprophylaxis Recommendation**	**Yes**
BCG/Mantoux		Japanese encephalitis		Atovaquone/proguanil	
Chikungunya		Meningitis ACWY		Doxycycline	
Cholera		MMR/MMRV		Mefloquine	
Dengue		Rabies		Chloroquine only	
Dip/tetanus/polio		TBE		Emergency standby	
Hepatitis A		Typhoid		Weight of child:	
Hepatitis B		Yellow fever		Any Further notes	
Hepatitis A+B		Other			
Influenza / COVID19					

Vaccine and General Travel Advice required/provided

Potential side effects of vaccines discussed Patient Information Leaflet (PIL) from packaging or from www.medicines.org.uk/emc/ given	

Patient consent for vaccination obtained: verbal ☐ written ☐

Post vaccination advice given: verbal ☐ written ☐

General travel advice leaflet given (all topics below in the surgery/clinic advice leaflet) and patient asked to read entire leaflet due to insufficient time to advise verbally on every topic: **Yes / No**

Items ticked below indicate topics discussed specifically within the consultation:

Prevention of accidents		Mosquito bite prevention	
Personal safety and security		Malaria prevention advice	
Food and water borne risks		Medical preparation	
Travellers' diarrhoea advice		Sun and heat advice	
Sexual health & blood borne virus risk		Journey/transport advice	
Rabies specific advice		Insurance advice	

Other specific specialised advice / information given on:
e.g. COVID-19 supportive advice, smoking advice for a long-haul flight; altitude advice; prevention of schistosomiasis etc.

Source of advice used for further information : NaTHNaC Other

OR no additional specialised advice given ☐

Additional patient management or advice taken following risk assessment – for example:

- Vaccine(s) patient declined following recommendation, and reason why
- Telephoned NaTHNaC for advice or used Malaria Reference Laboratory e mail service
- Contacted hospital consultant for specific information in respect of a complex medical condition
- Given appropriate advice in relation to pregnancy and planned conception if travelling to Zika risk area
- Identified specific nature/purpose of VFR travel

Authorisation for a Patient Specific Direction (PSD)

Following the completion of a travel risk assessment, the below named vaccines may be administered under this PSD (see the SPS website for more details):

Name: **dob:**

Name, form & strength of medicine (generic/brand name as appropriate)	**Dose, schedule and route of administration**	**Start and finish dates**

Signature of Prescriber	**Date**

Post Vaccination administration

Vaccine details recorded on patient computer record (vaccine name, batch no., stage, site, etc.)	**Y / N**
SMS vaccines reminder or post card reminder service set up	**Y / N**
Travel record card supplied or updated:	**Y / N**
Travel risk management consultation performed by: (sign name and date)	