**UNIVERSITY MEDICAL GROUP**

**TRAVEL RISK ASSESSMENT FORM**

**To be completed by traveller prior to appointment and emailed or given to reception at surgery.**

Please ensure that you complete as much of this form as possible and that you have fully read the information on our website. This form should be submitted  **eight weeks before you travel**.

We only give travel vaccines covered by the **NHS: Hepatitis A, Diptheria, Polio, Typhoid, MMR & Cholera**

All other vaccines will need to be obtained from a private travel clinic.

A separate form must be completed for each traveller

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | Date of birth: | | | | |
|  | | | | Male  Female | | | | |
| Email: | | | | Telephone number:  Mobile number: | | | | |
| Preferred method of contact:  Email or Telephone | | | |  | | | | |
| PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW | | | | | | | | |
| Date of departure: | | | | Total length of trip: | | | | |
| Have you taken out travel insurance for this trip? | | | | | | | | |
| |  |  |  | | --- | --- | --- | | COUNTRY TO BE VISITED | CITY OR RURAL | LENGTH OF STAY | | 1. |  |  | | 2. |  |  | | 3. |  |  | | 4. |  |  | | | | | | | | | |
| TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY | | | | | | | | |
| Holiday  Staying in hotel  Backpacking  Business trip Cruise ship trip  Camping  Expatriate  Safari  Adventure  Volunteer work  Pilgrimage  Diving  Healthcare worker  Medical tourism  Visiting friends/family  Additional information | | | | | | | | |
| PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY | | | | | | | | |
|  | | | | | Yes | No | | Details |
| Are you fit and well | | | | |  |  | |  |
| Any allergies including food, latex, medication | | | | |  |  | |  |
| Severe reaction to a vaccine before | | | | |  |  | |  |
| Tendency to faint with injections | | | | |  |  | |  |
| Recent chemotherapy/radiotherapy/organ transplant | | | | |  |  | |  |
| HIV/AIDS | | | | |  |  | |  |
| Immune system condition | | | | |  |  | |  |
|  | | | | | Yes | No | | Details |
| Women only | | | | |  |  | |  |
| Are you pregnant? | | | | |  |  | |  |
| Are you breast feeding? | | | | |  |  | |  |
| Are you planning pregnancy while away? | | | | |  |  | |  |
|  | | | | | | | | |
| Please list any medication that you are taking other than what is prescribed at this practice  eg: purchased over the counter | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| PLEASE SUPPLY INFORMATION ON ANY VACCINES YOU HAVE HAD IN THE PAST | | | | | | | | |
| Tetanus/polio/diphtheria | Date: |  | Typhoid | | | | Date: | |
| Hepatitis A | Date: |  | Pneumococcal | | | | Date: | |
| Cholera | Date: |  | MMR | | | | Date: | |
|  | | | | | | | | |
| Any additional information of other vaccines received: | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| Staff Use Only – 2 week turn around |  | Please Initial |
| Date Received by reception |  |  |
| Date given to clinical coders with MRE |  |  |
| Date passed to nurse from coders |  |  |