**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 practiceeg: 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 |  |  |