BOURNEMOUTH UNIVERSITY MEDICAL SERVICES
TRAVEL RISK ASSESSMENT FORM

Please complete this form prior to your travel appointment and return to reception. The Practice Nurse will evaluate the form and will be in touch with you in due course. Please allow 2 weeks for this to be done.

PERSONAL DETAILS:			
NAME:	**DATE OF BIRTH:**		
	MALE		**FEMALE**	
CONTACT TELEPHONE NUMBER:			
E-MAIL:			
DATE OF DEPARTURE:	**RETURN DATE OR OVERALL LENGTH OF TRIP:**		

COUNTRY TO BE VISITED:	**LENGTH OF STAY:**	**AWAY FROM MEDICAL HELP AT DESTINATION? IF SO, HOW REMOTE?**
1.		
2.		
3.		

TYPE OF TRIP:	BUSINESS		PLEASURE		OTHER	
HOLIDAY TYPE:	PACKAGE		SELF ORGANISED		BACKPACKING	
	CAMPING		CRUISE SHIP		TREKKING	
ACCOMMODATION:	HOTEL		RELATIVES/ FAMILY HOME		OTHER	
TRAVELING:	ALONE		WITH FAMILY/FRIEND		ALTITUDE	
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 ANY CURRENT OR REPEAT MEDICATIONS:
DO YOU HAVE ANY ALLERGIES TO FOOD, LATEX OR MEDICATION?
HAVE YOU EVER HAD A SERIOUS REACTION TO A VACCINE GIVEN BEFORE? IF SO, WHAT?

P.T.O.

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, PLANNING PREGNANCY OR BREAST FEEDING?
HAVE YOU TAKEN OUT TRAVEL INSURANCE AND IF YOU HAVE A MEDICAL CONDITION, INFORMED THE INSURANCE COMPANY?
PLEASE WRITE BELOW ANY FURTHER INFORMATION WHICH MAY BE RELEVANT:

VACCINATION HISTORY:					
HAVE YOU EVER HAD ANY OF THE FOLLOWING VACCINATIONS/MALARIA TABLETS AND IF SO, WHEN?					
TETANUS		POLIO		DIPHTHERIA	
TYPHOID		HEPATITIS A		HEPATITIS B	
MENINGITIS		YELLOW FEVER		INFLUENZA	
RABIES		JAPANESE ENCEPHALITIS B		TICK BOURNE	
OTHER		MALARIA TALBETS			

FOR DISCUSSION WHEN RISK ASSESSMENT IS PERFORMED WITHIN YOUR APPOINTMENT:

I have no reason to think that I might be pregnant. 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.

Signed _____ Date _____

COMPLETION BY TRAVEL NURSE

Vaccinations advised for travel itinerary as detailed above:

Diptheria/Tetanus/ Polio	**Typhoid**	**Hepatitis A**	**Hepatitis B**	**Yellow fever**
Meningitis ACWY	**Rabies**	**Japanese encephalitis**	**Tick-borne encephalitis**	**Cholera**

FOR OFFICIAL USE **PATIENT'S NAME:**				
TRAVEL RISK ASSESSMENT PERFORMED? SIGNATURE …….. POSITION …… DATE: ……..	YES		NO	

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 to

Name: _____ **DOB:** _____

Name of Vaccine	Dose and Schedule	Batch number	Site Given
			RA LA RL LL
			RA LA RL LL
			RA LA RL LL
			RA LA RL LL
			RA LA RL LL
			RA LA RL LL

Signature of Prescriber	Date

POST VACCINATION ADMINISTRATION

Vaccine details recorded on patient computer record (vaccine name, batch no, stage, site, etc)	**Y/N**
Travel rick management consultation performed by: (sign name and date)	