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

|  |  |
| --- | --- |
| Name: Full Name  | Date of birth: Date of Birth  |
|  | Male: [ ]  Female: [ ]   |
| E mail:       | Telephone number: Patient Home Telephone Mobile number: Patient Mobile Telephone  |
| **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.
 |       |       |       |
| 1.
 |       |       |       |
| 1.
 |       |       |       |
| 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 | [ ]   | [ ]   |       |
| Severe reaction to a vaccine before | [ ]   | [ ]   |       |
| Tendency to faint with injections | [ ]   | [ ]   |       |
| Any surgical operations in the past, including e.g. yourspleen or thymus gland removed | [ ]   | [ ]   |       |
| Recent chemotherapy/radiotherapy/organ transplant | [ ]   | [ ]   |       |
| Anaemia | [ ]   | [ ]   |       |
| Bleeding /clotting disorders (including history of DVT) | [ ]   | [ ]   |       |
| Heart disease (e.g. angina, high blood pressure) | [ ]   | [ ]   |       |
| Diabetes | [ ]   | [ ]   |       |
| Disability | [ ]   | [ ]   |       |
| Epilepsy/seizures | [ ]   | [ ]   |       |
| Gastrointestinal (stomach) complaints | [ ]   | [ ]   |       |
| Liver and or kidney problems | [ ]   | [ ]   |       |
| HIV/AIDS | [ ]   | [ ]   |       |
| Immune system condition | [ ]   | [ ]   |       |

Form devised and created by Jane Chiodini © updated 2017

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| Mental health issues (including anxiety, depression) | [ ]   | [ ]   |       |
| Neurological (nervous system) illness | [ ]   | [ ]   |       |
| Respiratory (lung) disease | [ ]   | [ ]   |       |
| Rheumatology (joint) conditions | [ ]   | [ ]   |       |
| Spleen problems | [ ]   | [ ]   |       |
| Any other conditions? | [ ]   | [ ]   |       |
| **Women only** |
| Are you pregnant? | [ ]   | [ ]   |       |
| Are you breast feeding? | [ ]   | [ ]   |       |
| Are you planning pregnancy while away? | [ ]   | [ ]   |       |
| Have you undergone FGM / been cut / circumcised | [ ]   | [ ]   |       |

**Are you currently taking any medication** (incl 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 |       | JapaneseEncephalitis |       | Tick BorneEncephalitis |       |
| Yellow fever |       | BCG |       | Other:       |
| 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. [www.rcn.org.uk](http://www.rcn.org.uk/)

2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.

Form devised and created by Jane Chiodini © updated 2017