

Coggeshall Surgery Travel Form

Personal Details			
Name & Address:		Date of Birth:	
.....		Male [] Female [] please tick	
.....			
Telephone Contact Number/s:			
Dates of Proposed Trip			
Date of Departure:			
Return Date/Overall Length of Trip:			
Itinerary & Purpose of Visit			
<u>Country to be visited</u>	<u>Length of Stay</u>	<u>Remote from medical help at destination?</u>	
		<u>If so, how remote?</u>	
1.			
2.			
Future travel plans			
Please tick as appropriate below to best describe your trip			
1. Type of Trip	Business	Pleasure	Other
2. Holiday type	Package	Self-organised	Backpacking
	Camping	Cruise ship	Trekking
3. Accommodation	Hotel	Relatives/family home	Other
4. Travelling	Alone	With family/friend	In a group
5. Staying in area which is	Urban	Rural	Altitude
6. Planned activities	Safari	Adventure	Other
Personal Medical History (please give details)			
Do you have any significant medical conditions or medical history?			
Any current or repeat medications?			
Any allergies (e.g. eggs, antibiotics, nuts)?			
Have you ever had a serious reaction to a vaccine?			
Does having an injection make you feel faint? Yes [] No []			
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 or planning pregnancy, or are you breast feeding?			
Have you taken out travel insurance and if you have a medical condition, have you informed the insurance company about it?			
Please give any further information which may be relevant			

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Vaccination History

Have you ever had any of the following vaccinations or malaria tablets? If so, when?

Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick-borne	
Other					
Malaria tabs					

For discussion when risk assessment is performed at 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.

Signature: Date

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Travel risk assessment performed Yes [] No []

Travel Vaccines Recommended for this trip

Disease Protection	Yes	No	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

Travel Advice and Leaflets Given as per Travel Protocol

Food water & personal hygiene advice		Travellers' Diarrhoea		Hepatitis B and HIV	
Insect Bite Prevention		Animal Bites		Accidents	
Insurance		Air Travel		Sun & Heat Protection	
Websites	Travel Record Card Supplied		Yes [] No []		
	Other				

Malaria Prevention Advice & Malaria Chemoprophylaxis

Chloroquine & Proguanil		Atovaquone + Proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria Advice Leaflet Given	

Further Information

e.g. Weight of Child

Completed by (signature) Position Date

Approved by GP (signature) Date

This form when completed should be scanned into the patient's medical record for evidence of best practice.