

Travel Risk Assessment Form

To be completed and returned to practice at least 6 weeks prior to travel



Forms can be returned to Reception, or sent by email to freshwell.administration@nhs.net

Patient Details			
Name		Date of birth	
Address		NHS number	
		Home Telephone	
Email		Mobile Telephone	

Travel Itinerary					
	Dates	Country	Exact location/region	City or Rural	Length of Stay
1.					
2.					
3.					
4.					

Travel Information (please tick all that apply)				
Type	<input type="checkbox"/> Holiday	<input type="checkbox"/> Business trip	<input type="checkbox"/> Volunteer work	<input type="checkbox"/> Visiting friends/family
	<input type="checkbox"/> Expatriate	<input type="checkbox"/> Cruise ship	<input type="checkbox"/> Healthcare worker	<input type="checkbox"/> Pilgrimage
Accommodation	<input type="checkbox"/> Hotel	<input type="checkbox"/> Camping	<input type="checkbox"/> Hostels	<input type="checkbox"/> Friends/Family
Activities	<input type="checkbox"/> Safari	<input type="checkbox"/> Diving	<input type="checkbox"/> Adventure	
Additional information:				

Medical History			
	Yes	No	Details
Are you fit and well today			
Severe reaction to a vaccine before			
Tendency to faint with injections			
Any surgical operations in the past, including e.g. your spleen 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			

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?			

Information on any vaccines or malaria tablets taken in the past					
Tetanus/Polio/Diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Japanese Encephalitis		Rabies		Yellow Fever	
Tick Borne Encephalitis		BCG		Other	
Malaria Tablets					

Allergies
Please amend this as necessary (include food, latex and medication)

Medications
Please amend this as necessary (include prescribed, purchased or contraceptive pill)
Acute Medication
Repeat Medication

Further Information
Have you taken out travel insurance for this trip?
Do you plan to travel abroad again in the future?
Other information:

OFFICE USE ONLY	Date of Receipt	
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