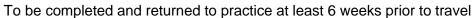
Travel Risk Assessment Form

Patient Details





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

Name		D				Date o	f birth	1			
Address						NHS n	umhe	or .			
						ne Telephone					
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	.,						- .				
En	nail				Mobile Telephone			9			
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Tra	avel Itinerary Dates		ountry		Evact lo	: location/region				or Rural	Length of Stay
1.	Dates	Country			Exact location/re		rregi	ion City		DI RUIAI	Length of Stay
٠.											
2.											
3.											
Э.											
4.											
Tra	avel Informa	tio	n (please tick a	II that	apply)						
Ту			□ Holiday		siness	□ V	olunte	eer wo	ork	□ Visiting	friends/family
	-			trip						J	·
			□ Expatriate		uise ship				vorker	□ Pilgrima	
	commodation	on	□ Hotel		mping		Hostels Friends/Family				
	tivities		□ Safari	□ Di\	/ing	□ A	dvent	ture			
Ad	lditional info	orm	ation:								
Me	edical Histor	У									
						7	Yes	No		De	tails
Are	e you fit and	wel	l today								
Se	vere reaction	ı to	a vaccine befo	re							
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					ant						
An	aemia										
Ble	eding /clottir	ng c	disorders (includ	ding hi	story of						
D۷											
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 vaccine		en in the past						
Tetanus/Polio/Diptheria	MMR		Influenza					
Typhoid	Hepatitis A		Pneumococcal					
Cholera	Hepatitis B		Meningitis					
Japanese Encephalitis	Rabies		Yellow Fever					
Tick Borne	BCG		Other					
Encephalitis								
Malaria Tablets								
Allergies								
Please amend this as necessary (include food, latex and medication)								
Medications								
	ssary (include prescribed	l nurchased o	r contracentive nill)					
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?								
T LIO VOIL DIAN TO TRAVELANTOAD								
Other information:								

OFFICE USE ONLY	Date of Receipt	