**PATIENTS ARE REMINDED THAT TRAVEL FROMS NEED TO BE COMPLETED AT LEAST 6 WEEKS BEFORE TRAVELLING**

**BROWNSOVER MEDICAL CENTRE, BOW FELL, BROWNSOVER CV 21 1JF – 01788 435214**

PERSONAL DETAILS

|  |  |  |
| --- | --- | --- |
| NAME | | DOB  MALE / FEMALE |
| EASIEST CONTACT TELEPHONE NUMBER | |  |
| DATE OF DEPARTURE | |  |
| RETURN DATE | |  |
| **COUNTRY / COUNTRIES TO BE VISISTED AND AREAS** | **LENGTH OF STAY** | **WILL YOU BE AWAY FROM MEDICAL HELP AT YOUR DESTINATION? IF SO, HOW REMOTE?** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

PLEASE TICK [ } THE FOLLOWING

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| TYPE OF TRIP | BUSINESS |  | PLEASURE |  | OTHER |  |
| HOLIDAY TYPE | PACKAGE |  | SELF ORGANISED |  | BACKPACKING |  |
| CAMPING |  | CRUISE SHIP |  | TREKKING |  |
| ACCOMADATION | HOTEL |  | RELATIVES/FAMILY HOME |  | OTHER |  |
| TRAVELLING | ALONE |  | WITH FAMILY/FRIENDS |  | IN A GROUP |  |
| STAYINH IN AREA WHICH IS … | URBAN |  | RURAL |  | ALTITUDE |  |
| PLANNED ACTIVITIES | SAFARI |  | ADVENTURE |  | OTHER |  |
|  | | | | | | |
| DO YOU HAVE ANY ALLERGIES? FOR EXAMPLE, TO EGGS, ANTIBIOTICS, NUTS? | | | | | | |
| HAVE YOU EVER HAD A SERIOUS REACTION TO A VACCINE GIVEN TO YOU BEFORE? | | | | | | |
| 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 RADIOTHERPHY, CHEMOTHERAPY OR STEROID TREATMENT? | | | | | | |
| WOMEN ONLY: ARE YOU PREGNANT / PLANNING PREGNACY/ OR BREASTFEEDING? | | | | | | |

VACCINATION HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HAVE YOU EVER HAD ANY OF THE FOLLOWING VACCINATION OR MALARIA TABLETS | | | | | |
| TETANUS |  | POLIO |  | DIPTHERIA |  |
| TYPHOID |  | HEPATITIES A |  | HEPATITIS B |  |
| MENINGITIS |  | YELLOW FEVER |  | INFLUENZA |  |
| RABIES |  | JAP B ENCEPH |  | TICK BORNE |  |
| OTHER | | | | | |
| MALARIA TABLETS | | | | | |

**Patient signature:………………………………………………………………………………..**

**Date of completion of form: ……………………………………………………………..**

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**For office use only:**

|  |  |
| --- | --- |
| Form checked by: | Date: |
| Vaccinations required YES/NO |  |
| Details of vaccinations ordered (if applicable): | Date ordered (from Head Office): |
| Vaccine costs (to patient – if applicable):  £ | ***If cost involved, it must be paid by patient before vaccine is ordered – Tracey should be informed*** |
| Appointment required YES/NO | If yes, after what date: |
| Appointment with (please circle) Nurse George Nurse Alison | |
| Information entered on to EMIS: YES/NO | |
| Reception action (free text instructions for Reception to relay to patient):  *Further travel advice can be found at https://travelhealthpro.org.uk/* | |
| Contact made with patient (by Reception): (insert name) Date: | |
| Vaccine cost (if applicable) paid by patient: | |

***Practice Nurse to complete form & return to reception for action. Form to be scanned into patient record (non-workflow)***