



PATIENTS ARE REMINDED THAT TRAVEL FORMS 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 VISITED 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		DIPHTHERIA	
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:

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): £	<i>If cost involved, it must be paid by patient before vaccine is ordered – Tracey should be informed</i>
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):	
<i>Further travel advice can be found at https://travelhealthpro.org.uk/</i>	
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)