

TRAVEL RISK ASSESSMENT FORM

Please complete this form and hand in to the Practice

Name:		Your country of origin:		
		Date of birth:		
		Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/>		
E mail:		Telephone number:		
		Mobile number:		
PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW				
Date of departure:		Total length of trip:		
COUNTRY TO BE VISITED	EXACT LOCATION OR REGION	CITY OR RURAL	LENGTH OF STAY	
1.				
2.				
3.				
What modes of transport will you be using? Have you taken out travel insurance for this trip? Do you plan to travel abroad again in the future?				
TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY				
<input type="checkbox"/> Holiday <input type="checkbox"/> Staying in hotel <input type="checkbox"/> Backpacking				<u>Additional information</u>
<input type="checkbox"/> Business trip <input type="checkbox"/> Cruise ship trip <input type="checkbox"/> Camping/hostels				
<input type="checkbox"/> Expatriate <input type="checkbox"/> Safari <input type="checkbox"/> Adventure				
<input type="checkbox"/> Volunteer work <input type="checkbox"/> Pilgrimage <input type="checkbox"/> Diving				
<input type="checkbox"/> Healthcare worker <input type="checkbox"/> Medical tourism <input type="checkbox"/> Visiting friends/family				
PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY				
	YES	NO	DETAILS	
Are you fit and well today				
Any allergies including food, latex, medication				
Have you, or anyone in your family, had a severe reaction to a vaccine or malaria medication before?				
Tendency to faint with injections				
Any surgical operations in the past, including e.g. open-heart surgery, spleen or thymus gland removal?				
Recent chemotherapy/radiotherapy/organ transplant				
Anaemia				
Bleeding /clotting disorders (including history of DVT)				
Heart disease (e.g. angina, high blood pressure)				
Diabetes				
Additional needs and/or disability				
Epilepsy/seizures (or in a first degree relative?)				
Gastrointestinal (stomach) complaints				
Liver and or kidney problems				
HIV/AIDS				

	YES	NO	DETAILS
Immune system condition e.g. blood cancer			
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
Are you or your partner pregnant or planning a pregnancy?			
Are you breast feeding (if applicable)			
Have you or anyone in your family undergone FGM / been cut / circumcised			

Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?

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PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST

Tetanus/polio/diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies		Japanese encephalitis		Tick borne encephalitis	
Yellow fever		BCG		Other	
COVID-19 (dates, brand etc.)					
Malaria Tablets					

Any additional information

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Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine*. RCN, London.
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.