TRAVEL RISK ASSESSMENT FORM – ideally to be completed by traveler prior to appointment.

Name:	Your country of origin:
	Date of birth:
	Male ☐ Female ☐ Non-binary ☐
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

☐ Holiday	☐ Staying in hotel	☐ Backpacking	Additional information
☐ Business trip	☐ Cruise ship trip	☐ Camping/hostels	
☐ Expatriate	☐ Safari	☐ Adventure	
☐ Volunteer work	☐ Pilgrimage	☐ Diving	
☐ Healthcare worker	☐ Medical tourism	☐ 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			
Anemia			
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			

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	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)?

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

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.

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Patient Name:-
Travel risk assessment performed Yes [ ] No [ ]

Travel vaccines recommended for this trip			
Disease protection	Yes	No	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

Travel advice and leaflets given as per travel protocol					
Food, water and personal hygiene advice		Traveler's diarrhea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air Travel		Sun and heat protection	
Websites		Travel Record card supplied			
		Other			

Malaria prevention advice and malaria chemoprophylaxis			
Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further information
e.g. weight of child
Signed by: …………………………………………. Position: ……………………………………………………. Date: ………………………

Now scan this form into the patient's record on the computer for evidence of best practice.