# Travel Risk Assessment Form.

We are not a specialised Travel Clinic and therefore we need to place some restriction on what we can offer you as travellers. Your nearest Travel Clinic is Regent Street, Nottingham (Tel: 0115 947 5498) or Website: www.masta.org – please contact if your itinerary is complicated, i.e;

1. Multiple Destinations – More than 1 country. Please note travel advice within the surgery is for the country and not specific areas due to be visited.
2. Prolonged Stays – More than 4 weeks.
3. Last Minute Travellers – Presenting **10 days or less** before departure.

| | | | |
|---|---|---|---|
| Name: | | Date of Birth: | |
| Telephone Number: | | Mobile Number: | |
| Male<br>Female | | Email: | |

**Please Supply Information About Your Trip In The Section Below:**

| | |
|---|---|
| Date of Departure: | Flight Stop Overs: |
| Country to Be Visited: | Exact Location or Region: |
| City or Rural: | Length of Stay: |
| Have you taken out travel insurance for this trip?<br><br>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: | | Camping/Hotels: | | |
| Business Trip: | | Cruise Ship Trip: | | Adventure: | | |
| Expatriate: | | Safari: | | Diving: | | |
| Volunteer Work: | | Pilgrimage: | | Visiting Friends/Family: | | |
| Healthcare Worker: | | Medical Tourism: | | | | |

**Please Supply Details of Your Personal Medical History:**

| | Yes | No | Details |
|---|---|---|---|
| Are you fit and well today? | | | |
| Any allergies including food, latex, medication? | | | |
| Severe reaction to any vaccine before? | | | |
| Tendency to faint with injections? | | | |
| Any surgical operations in the past, including: | | | |
| Your spleen or Thymus gland removed? | | | |
| Recent Chemotherapy / radiotherapy / organ transplant? | | | |
| Anaemia? | | | |
| Bleeding / clotting disorder (including history of DVT)? | | | |
| Heart Disease (e.g. Angina, High blood pressure)? | | | |
| Diabetes? | | | |
| Disability? | | | |
| Epilepsy / Seizures? | | | |
| Gastrointestinal (stomach) Complaints? | | | |
| Liver or Kidney problems? | | | |
| HIV / AIDs? | | | |
| Immune system condition? | | | |

| | Yes | No | Details |
|---|---|---|---|
| Mental Health Issues? (Including anxiety, depression) | | | |
| Neurological (nervous system) Illness? | | | |
| Respiratory (lung) Disease? | | | |
| Rheumatology (joint) Condition? | | | |
| Spleen problems? | | | |
| Any Other Condition? | | | |

**Women Only**

| | | | |
|---|---|---|---|
| Are you Pregnant? | | | |
| Are you breast feeding? | | | |
| Are you planning pregnancy whilst away? | | | |

Are You Currently Taking **Any** Medication? (Including; Prescribed, Purchased or Contraceptive Pill)

**For Office Use Only. Vaccines Recommended For Travel:**

| | | | | | |
|---|---|---|---|---|---|
| Tetanus / Polio / Diphtheria | | MMR | | Influenza | |
| Typhoid | | Hepatitis A | | Pneumococcal | |
| Cholera | | Hepatitis B | | Meningitis | |
| Rabies | | Japanese Encephalitis | | Tick Borne Encephalitis | |
| Yellow Fever | | BCG | | Other | |
| Malaria Tablets | | | | | |

Any Additional Information:

Authorisation for Patient Specific Direction (PSD) Use:

Assessor's Name: Signature: Date:

Prescriber's Name: Signature: Date: