



Travel Risk Assessment Form

Name:

Date of Birth:

Address:

Telephone:

Email:

Travel Details

Departure Date:

Total Length of Trip:

Return Date:

Country/Destination

Region

Length of Stay

1.

2.

3.

4.

5.

6.

7.

8.

Purpose of Trip

Adventure/Gap Year:

Aid Work/Emergency Response:

Business/Work Trip:

Charity/Volunteer:

Cruise:

Diving:

Health Worker:

Holiday:

Long Term/Expatriate

Medical Treatment:

Pilgrimage:

Visiting Friends and Family:

Other:

Medical History

Please tick either the 'Yes' or 'No' answer box. If you answer yes to any of the questions, please give dates and full details overleaf.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1) Do you have, or have you had any serious illness, disability or mobility problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you receiving regular treatment or follow up with your GP/Hospital specialist? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--|--------------------------|--------------------------|
| 3) Have you had <u>any</u> hospital admissions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Have you ever had any Surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Do you have any allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Have you had any travel related illness/injury which required assessment/treatment in hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Do you have a condition which may suppress your immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Do you think you have a condition which may be affected by travel? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Do you have any specific health concerns regarding your proposed trip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Have you ever experienced any mental health issues, even mild anxiety or depression? | <input type="checkbox"/> | <input type="checkbox"/> |

Further Details

Please provide any other information regarding your health, including problems experienced with previous travel:

Please continue on separate sheet if necessary.

Are you taking any form of medication?

Yes No

If yes please give details including prescribed/self-treatment/over the counter remedies and contraception

Name of Medication	Dose and Frequency	Condition

Women Only

Are you pregnant, breastfeeding or planning pregnancy whilst travelling?

Babies and Children Only

Current Weight:

Date:

Do you have travel health Insurance? Yes No

Next section is for health professional use only:

Risk Management Checklist	Discussed (✓)	Comments
1. Medical prep		
2. Journey and Transport advice		
3. Personal Safety and Security		
4. Environmental		
5. Food and Water borne risks		
6. Vector-borne risks		
7. Sexual Health		
8. Blood-borne virus		
9. Sun and Heat advice		
10. Rabies Advice		
11. Psychological Health		
12. Other specific specialised advice/information given: e.g altitude, smoking on long haul etc.		
Potential side effects of vaccines discussed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Patient consent for Vaccine obtained Verbally/Written	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Signature..... Date.....

Vaccine Record

Vaccines	Date	Brand, Batch & Expiry Date	Dose, method & site	Given by
BCG & Mantoux Test Mantoux result				
Cholera Primary Course: Boosters				
Diphtheria/tetanus/polio				
Hepatitis A Primry Course: Boosters				
Hepatitis B Primary Course: Boosters				
Japanese Encephalitis Primary Course Boosters				
Influenza				
Meningitis ACWY				
Rabies				
MMR				
Tick Bourne Encephalitis Primary Course Boosters				
Typhoid				

Cholera (Oral)				
Yellow Fever				
Any other Vaccines				

Malaria

Antimalarials	Date Prescribed	Dose & Amount Dispensed	Batch No & Expiry Date	Given by
Atovaquone & proguanil				
Chloroquine				
Doxycycline				
Mefloquine				
Proguanil				
Emergency Standby				
Importance of bite avoidance and urgent medical attention for symptoms discussed?				
Yes <input type="checkbox"/> No <input type="checkbox"/>				
Any other advice or comments.				

The General Data Protection Regulation (GDPR) is a new law that determines how your personal data is processed and kept safe, and the legal rights that you have in relation to your own data.

The regulation applies from 25 May 2018, and will apply even after the UK leaves the EU.

Please see our website for further information on our Privacy Statement

<http://dyfivalleyhealth.org>

Telephone: Dyfi Valley Health 01654 702224