UNIVERSITY MEDICAL GROUP

TRAVEL RISK ASSESSMENT FORM

To be completed by traveller prior to appointment and emailed or given to reception at surgery.

Please ensure that you complete as much of this form as possible and that you have fully read the information on our website. This form should be submitted **eight weeks before you travel**. We only give travel vaccines covered by the **NHS**: **Hepatitis A, Diptheria, Polio, Typhoid, MMR & Cholera**

All other vaccines will need to be obtained from a private travel clinic.

A separate form must be completed for each traveller

Date of birth: Male											
Email: Preferred method of contact: Email or Telephone PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW Date of departure: Total length of trip: Have you taken out travel insurance for this trip? COUNTRY TO BE VISITED CITY OR RURAL LENGTH OF STAY 1. COUNTRY TO BE VISITED SUBJECT OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY Holiday Staying in hotel Business trip Cruise ship trip Staying in hotel Backpacking Cruise ship trip Adventure Volunteer work Healthcare worker Healthcare worker Mobile number:	Name:			Date of birth:							
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friends/family					L						
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Additional information											
	Additional information										

PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY										
				Yes	s	No)	Details		
Are you fit and well]			
Any allergies including food, latex, medication						╁				
						┢]			
Severe reaction to a vaccine before						┢]			
Tendency to faint with injections						<u> </u>	1			
Recent chemotherapy/radioth	nerapy/organ tra	nsplant		<u> </u>		<u> </u>	1			
HIV/AIDS				<u>Ц</u>		<u> </u>				
Immune system condition				Ш						
				Yes	S	No)	Details		
Women only										
Are you pregnant?										
Are you breast feeding?										
Are you planning pregnancy	while away?			Ħ		Ī				
- 10 you planning programoy mino away.										
Please list any medication that you are taking other than what is prescribed at this practice										
eg: purchased over the counter										
PLEASE SUPPLY INFORMA	TION ON ANY	VACCINI	ES VOLL	ЦΛ\	/⊏	Ц ^	ד ואו ד	HE DACT		
PLEASE SUPPLY INFORMA	TION ON AINT	VACCIIVI	23 100	ПА	<i>/</i>	1 1/-	ו אוו טא	HE FAST		
Tetanus/polio/diphtheria	☐ Date:		Typhoi	Typhoid		T	Date:			
retarias/polio/alpritrieria	Date.		l i ypiioi	J			Date.			
Hepatitis A	Date:	Pneun		000	200	, I	□ Dat	to:		
riepatitis A	□ Date.	Fileum		Hococcai		11	Date:			
Chalara	□ Data:		NANAD					<u> </u>		
Cholera	☐ Date:		MMR				Date:			
Any additional information of	other vaccines r	eceived:								
Staff Use Only – 2 week turn around			Р				lease Initial			
Date Received by reception										
Date given to clinical coders with										
Date passed to nurse from code										