

PRIVATE AND CONFIDENTIAL

Surname:		First name:		Gender:	
Address:					
	Postcode:				
Email:		Contact number:			
Employer (if attending for overseas posting):			DOB:		

ITINERARY & PURPOSE OF VISIT

Country/countries to be visited	Departure Date	Length of trip	Reason for trip: Holiday/Business/Study/Volunteering/Sport

LOCATION AND ACCOMMODATION – Please tick all that apply.

Location	Tick	Type of trip	Tick	Type of accommodation	Tick
Coastal areas		Backpacking		All inclusive package	
Inland/rural areas		Organised trip		4 /5 * Hotels	
Urban areas		Independent travel		Other hotels / guest houses	
Safari		Pilgrimage		Hostels	
Jungle		Visiting friends/relatives		Safari Lodge	
High altitude		Healthcare elective		Camping/sleeping rough	
Remote locations		Community volunteering		Friends / Relatives	
Areas of civil unrest		School trip		Cruise ship/boat	
Ocean/river		Sport related			

VACCINATION HISTORY.

Please provide details of vaccinations you have had in the past (date/year): (B = Booster dose)

Vaccine	Date/s	Vaccine	Date/s	Vaccine	Date/s
Tetanus		Diphtheria		Polio	
Rabies	1 st 2 nd 3 rd B	Hepatitis A	1 st 2 nd B	Hepatitis B	1 st 2 nd 3 rd B
MMR		Yellow Fever		Typhoid	
Cholera		BCG		Meningitis ACWY	
Japanese B Encephalitis	1 st 3 rd 2 nd		Tick Borne Encephalitis	1 st 3 rd 2 nd	

MEDICAL HISTORY. Please answer the following questions:

Question	Answer	Details
Do you have any medical conditions?	Yes/No	
Are you taking any medication?	Yes/No	Please list all:
Have you received any live vaccinations in the past 3 months?	Yes/No	
Have you received radiotherapy, chemotherapy or steroid therapy in the past year?	Yes/No	
Are you taking any medication that affects your immune system? Please give details.	Yes/No	
Do you have a condition that affects your immune system eg HIV?		
Do you have any allergies to drugs, substances (eg latex) or foods, including eggs or chicken protein?	Yes/No	
Have you had a serious reaction to a vaccination in the past?	Yes/No	
Does having an injection make you feel faint?	Yes/No	
Females only: Are you pregnant, breastfeeding, or planning to become pregnant in the near future?	Yes/No	
Are you fit and well today? (eg no acute infection or high temperature)	Yes/No	

Date: ____ / ____ / ____

Signature: _____

Subsequent visits

Date	Has there been any change in your health since previous declaration? If yes, give details.	Signature

To be completed by Travel Consultant (Clinic reference for risk assessments: Travel Health Pro)

Date	Notes	Signature
	Visiting yellow fever endemic areas Yes/No	
Source of advice for all Robens travel risk assessments is 'Travel Health Pro' (NaTHNaC)		

Consent: *I have received information on the risks and benefits of the vaccines recommended and consent to the vaccines being administered.*

Please note: You are advised to inform your GP of the vaccinations you have received at the Robens.

Signature of Traveller: _____ Date: ____/____/____

To be completed by Travel Consultant

	Course	Date	Date	Date	Date
HEPATITIS B Day 0,7,21 & 1 yr Day 0, 1m,2m & 1yr Day 0, 1m & 6m					
TWINRIX Day 0,7,21 & 1yr Day0,1m & 6m					
RABIES Day 0,7 & 28 Day 0,7 & 21					
Japanese B Encephalitis Day 0 & 28 Day 0,7					
Tick-borne Encephalitis Day 0, 1-3m, 5-12 m after 2 nd Day 0, 14 days, 5-12 m after 2 nd					

TRAVEL ADVICE AND LEAFLETS GIVEN TO PATIENT

Vaccine PILs & side effects of vaccines discussed		Rabies risk/action		Malaria risk/advice	
Robens travel booklet		Altitude		Food and water precautions	
Post-vaccination advice		Blood borne infections (Hep B/HIV)		DVT prevention	
Insect/mosquito bite prevention - PHE leaflet given		Sun/heat protection		Country specific information	
Sexual health		Traveller's diarrhoea		Insurance advice	
Zika virus		NaTHNac YF leaflet		Personal safety/security	
Other advice given:					

MALARIA RISK ASSESSMENT AND SUPPLY OF CHEMOPROPHYLAXIS

NAME: _____ DOB: ____/____/____

In order to assess your suitability for malarial chemoprophylaxis, please answer the following questions about your health and any medication you are taking.

Condition		Yes/No
Pregnancy	Actual number of weeks: _____	
	Planned while on trip or afterwards	
Sickle cell	Disease	
	Carrier	
Thalassaemia	Disease	
	carrier	
Epilepsy	Patient	
	First degree relative*	
History of depression requiring treatment		
Severe mental health disorder	Patient	
	First degree relative*	
Asplenic		
Liver disease		
Renal failure (state eGFR)		
Diabetes Mellitus		
Cardiovascular	Ischaemic heart disease	
	Arrhythmias	
	Other	
Immunocompromised		
Psoriasis		

*First degree relatives are included in the risk assessment as a precaution since risk of epilepsy and major depression is higher in first degree relatives of those in whom these conditions have been diagnosed. A condition in a first-degree relative may not contraindicate the use of an antimalarial, but may influence the choice of drug.

Give details of allergies to drugs or other below

Current medication	Yes/No	Comments
Antiarrhythmics		
Anconvulsants		
Anticoagulants		
Antiretrovirals		
Corticosteroids		
Bupropion (Zyban)		
Other		

Previous antimalarial chemoprophylactic agents taken	Describe any problems

Signature of Traveller: _____ Date: ____/____/____

FOR COMPLETION BY TRAVEL PROFESSIONAL:

Record of malarial advice and supply of chemoprophylaxis:

Antimalarial	Tick	Date supplied	No.	Batch no	Exp date	Signature
Doxycycline 100mg						
Atovaquone/ Proguanil 250mg/100mg						
Mefloquine 250mg						

Advice about taking medication and course duration	Yes/No	Advice re malaria recognition/treatment	Yes/No
Advice about side effects	Yes/No	Advice re bite prevention methods (clothing, repellent, nets, coils/vapourisers, insecticides)	Yes/No

GP letter given to client

Name of Travel Consultant: _____

Signature: _____ Date: ____ / ____ / ____