Robens Centre
Travel Health and Vaccination Clinic

1 Huxley Road
The Surrey Research Park
Guildford Surrey, GU2 7RE
T: 01483 686690 F: 01483 686691

E mail: info@rcohs.com
Web: www.rcohs.com

TRAVEL RISK ASSESSMENT – PRIVATE AND CONFIDENTIAL

NAME ……

Date of birth……

ADDRESS ……

……

Contact No Home …… **Mobile/Work** ……..

Email ……..

How did you find out about the Robens Centre? ……..

Please tick if you do not wish to receive further information/updates from The Robens Centre	

Company you work for (if applicable) ……..

ITINERARY & PURPOSE OF VISIT

Destination	Departure Date	Length of Stay	Holiday/Business/Other

ACCOMMODATION –
Please tick all that apply with any details.

Does your journey include the following? –
Please tick all that apply

Coastal areas			**Type of accommodation**		**Duration of stay**
Inland/rural areas			4 /5 * Hotels		
Urban areas			Other hotels / guest houses		
Safari/jungle			Hostels		
High altitude			Camping / sleeping rough		
Charity/project work			Cruise ship		
Adventure trip/backpacking			Safari Lodge / Hostel		
Remote locations			Friends / Relatives		
Areas of civil unrest			Other		

Previous countries visited:	

VACCINATION HISTORY- Have you had any of the following and if so when?
(Please give dates of when vaccine administered)

Tetanus	**Diphtheria**	**Polio**
Typhoid	**Hepatitis A**	**Hepatitis B**
Meningitis	**Yellow Fever**	**Rabies**
Japanese B Encephalitis	**Tick Borne Encephalitis**	**Influenza**
MMR	**Cholera**	**BCG**
Other	**Malaria medication**	

MEDICAL HISTORY (please answer Yes/No)	**Yes**	**No**
Do you have any medical problems / chronic illnesses?	☐	☐
Are you taking any medication or received any vaccines in the last 3 weeks?	☐	☐
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?	☐	☐
Do you have an illness that affects your immune system (HIV, AIDS etc)?	☐	☐
Do you have any allergies to drugs, substances or foods including eggs?	☐	☐
Have you had a serious reaction to a vaccination in the past?	☐	☐
Does having an injection make you feel faint?	☐	☐
Is there any chance of pregnancy/are you planning pregnancy/are you breastfeeding?	☐	☐
Are you fit and well today?	☐	☐

VACCINES GIVEN (To be completed by travel consultant)

DATE	VACCINE	BATCH NO	EXP DATE	SITE	SIGNATURE

VACCINES GIVEN Continued (To be completed by travel consultant)

DATE	VACCINE	BATCH NO	EXP DATE	SITE	SIGNATURE

MALARIA MEDICATION

Some anti-malaria medications are contraindicated with certain conditions /situations.
Please tick appropriate box and discuss with the Travel Clinic Nurse.

	Yes	No
History of fitting / epilepsy	☐	☐
History of severe headaches or migraines	☐	☐
Severe depression or other mental health problems in self or family	☐	☐
Liver or kidney condition	☐	☐
Pregnancy, planned pregnancy or breastfeeding	☐	☐
Taking other anti-malarial medications	☐	☐
Scuba or commercial diving	☐	☐
Commercial or private flight deck crew	☐	☐

DATE	MALARIA MEDICATION DISPENSED	BATCH NO	EXP DATE	AMOUNT	SIGNATURE

Malaria advice for children: Date:

Weight of child: Recommended prophylaxis and dose:

TRAVEL ADVICE AND LEAFLETS GIVEN TO PATIENT

Letter following vaccination		Animal bites / rabies risk		Malaria advice	
General travel advice pack		Air travel health issues Altitude sickness		Malarone	
Website and other useful contacts		Hepatitis B HIV/Blood borne infections		Doxycycline	
Insect bite avoidance		Doxycycline & contraceptive advice		Mefloquine	
Backpackers information pack		Travellers Diarrhoea		Chloroquine & Proguanil	
Other information given:					

Vaccine	Tick course	Vaccine 1 - Date	Vaccine 2 - Date	Vaccine 3 -Date	Vaccine 4 - 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					
Japanese B Encephalitis Day 0, & 28 Day 0, 7 & 28					

Consent*: I have no reason to think I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and consent to the vaccines being administered.*

Signature of Traveller or Parent /guardian if under 16 yrs..……..……..Date……

Signature of Health Professional …….....Date ……..

NB. Anyone aged 16 years or over may give consent as above. In the case of a young person please use the supplementary consent form: under 16 years old Competency Assessment Form

Date	Notes	Signature