

**GP practice Travel Risk Assessment and Patient Specific Direction for administration of travel vaccines**

**\*\*Page 1 to be completed by the patient in advance and returned to the practice at least 1 week before their appointment\*\***

Patient Name:	Date of birth:
NHS number:	Address:
Contact number:	Email:

Trip Information	
Departure date:	Duration:

Itinerary		
Country including specific area or region	Duration	Availability of medical help (If travelling to a place where medical help is not readily on hand, estimate time it would take to reach a Doctor)

Trip description – tick all boxes that are applicable			
Purpose of trip:	Business <input type="checkbox"/>	Pleasure <input type="checkbox"/>	Other <input type="checkbox"/>
Type of trip:	Package holiday <input type="checkbox"/>	Self-organised <input type="checkbox"/>	Backpacking <input type="checkbox"/>
	Camping <input type="checkbox"/>	Cruise ship <input type="checkbox"/>	Trekking <input type="checkbox"/>
Accommodation	Hotel <input type="checkbox"/>	Friends/family <input type="checkbox"/>	Other <input type="checkbox"/>
Travelling	Alone <input type="checkbox"/>	With friends/family <input type="checkbox"/>	In a group <input type="checkbox"/>
Location	Urban <input type="checkbox"/>	Rural <input type="checkbox"/>	Altitude <input type="checkbox"/> (over 3000m or 10,000ft)
Activity type	Leisure <input type="checkbox"/>	Safari <input type="checkbox"/>	Adventure <input type="checkbox"/>

Medical History			
Chronic medical condition(s)			
Allergies (including eggs, nuts, antibiotics etc.)	<b>(Do not leave blank if none state NKDA)</b>		
Have you had a serious reaction to a vaccine in the past? Please tick	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, which vaccine and reaction?	
Current medications			
Recent infection? (high temp, flu, heavy cold)		Does having an injection make you feel faint?	
History of epilepsy yourself or family?		Any history of mental illness (Incl depression, anxiety)?	
Recent radiotherapy, chemotherapy or steroid treatment?		Are you pregnant, planning pregnancy or breastfeeding?	
Have you got travel insurance?		If you have a medical condition have you told your insurance company?	

**For discussion when risk assessment is performed within your appointment:**

I have no reason to think that I might be pregnant. I agree to pay for any vaccinations required for travel which are not available on the NHS. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Patient/parent signature:	Date:
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Travel risk assessment completed by:

**Travel vaccinations recommended for this trip**

Vaccinations suitable for prescribing on the NHS			
Disease protection	Required?		Further information
	Yes	No	
Hepatitis A single vaccine (Avaxim®, Havrix®, VAQTA®, Epaxal®)			
Typhoid (Typherix®, Typhim Vi®)			
Cholera (Dukoral®)			
Tetanus	Boostrix®		
Diphtheria	Infanrix-IPV®		
Polio	Repevax®		

Vaccinations not suitable for prescribing on the NHS			
PRIVATE CHARGE FOR THESE VACCINATIONS			
Disease protection	Required?		Further information
	Yes	No	
Hepatitis B vaccine (Engerix B®, Fendrix®, HBVAXPRO®) <b>**If both Hep A and Hep B are required DO NOT PRESCRIBE TWINRIX combination vaccine on NHS except when there are supply issues of individual vaccines**</b>			
Japanese B Encephalitis (Ixiaro®)			To be given at a private clinic
Meningitis ACWY (Menveo®, Nimenrix®)			
Rabies (Rabipur®, Rabies (generic))			
Yellow Fever (Stamaril®)			
Other			

**Malaria chemoprophylaxis**

**This is not available on the NOT suitable for prescribing on the NHS**

	Required?		Advice on supply
	Yes	No	
Chloroquine			P medicine can be purchase OTC or Private prescription
Chloroquine and proguanil			
Atovaquone + proguanil (Malarone)			POM Private prescription
Mefloquine			
Doxycycline			
Malaria advice given Yes <input type="checkbox"/>			

Zika virus advice given where necessary Yes

Doctor authorising administration of vaccination(s):

Date: