MARCHMONT MEDICAL PRACTICE

10 Warrender Park Terrace, Edinburgh

Telephone: 0131 229 6314

TRAVEL ASSESSMENT FORM – FOR PATIENT COMPLETION

Please complete the first page with as much detailed information about your travel as possible

Name:	**Your GP Surgery:**	**Date of 1st appointment**
Date of birth	**Telephone No:**	
Address:		

PERSONAL PROFILE

Significant past medical history:
(Including a history of mental illness, depression or anxiety)

Current health problems:

Allergies to: eggs YES NO

Antibiotics YES NO

Other:

Pregnant, or planning to be?

(Please tick if applicable) YES NO

Breastfeeding: YES NO

TRAVEL PROFILE

Reason for travel (Please tick)

Work **Recreational**

Date of departure

Region travelling to:

Country	**Length of Stay**	**Rural or city?**

Type of accommodation (Please tick)

Hotel

Apartment

Hostel

Tents

Others, please specify:

Previous Travel Experience / General Comments:

Name:	**DOB:**
PRACTICE USE ONLY	

PREVIOUS VACCINE HISTORY

VACCINE	Date last given	Need today	VACCINE	Date last given	Need today
Tetanus			Rabies		
Diphtheria			Jap B enc.		
Polio			Cholera		
Typhoid			Tick borne enc.		
Hep A 1st boost			Yellow fever		
Hep B 1st, 2, 3 boost			BCG		
Meningitis			Influenza/Pneumavac		

PLANNED VACCINE SCHEDULE FOR CURRENT TRIP

Vaccine	**Recommended For current trip?**	**Vaccination & date given**	**Manufacturer Batch No Exp Date**	**Site given**	**Signature**
Tetanus					
Diphtheria					
Polio					
Typhoid					
Meningococcal ACWY					
Yellow Fever					
Hepatitis A					**6 month – 1 year booster advised?** YES NO
BCG					**To consult RIE clinic?** YES NO
Varicella					

Name:	**DOB:**

PRACTICE USE ONLY

COMBINED VACCINES

Vaccine	**Recommended For current trip?**	**Vaccination & date given**	**Manufacturer Batch No Exp Date**	**Site given**	**Signature**

MULTIPLE DOSE VACCINES

Vaccine	**Recommended For current trip?**	**Vaccination & date given**	**Manufacturer Batch No Exp Date**	**Site given**	**Signature**

Patient declaration:
I confirm the answers I have given to be correct to the best of my knowledge and consent to the administration of the vaccines, the nature of which has been explained to me including potential side effects.

I request travel advice including immunisations and anti-malaria measures Yes ☐ No ☐

Signature : Date :

Name:	**DOB:**

PRACTICE USE ONLY	
Travax printout given to patient?	YES NO
Vaccine record card given to patient?	YES NO
Further information (if applicable)	

MALARIA	
Is there a risk of Malaria	YES NO
Awareness, understanding of how it is contracted, symptoms	YES NO
Bite avoidence (nets, repellents, etc)	YES NO
Signs, symptoms, diagnosis	YES NO
Written info given to patient	YES NO
Weight of child (if applicable)	

Food and water	WRITTEN DISCUSSED
Travelers' Diarrhoea	WRITTEN DISCUSSED
Insect bites	WRITTEN DISCUSSED
Accidents	WRITTEN DISCUSSED
Health Insurance	WRITTEN DISCUSSED
Safe Sun	WRITTEN DISCUSSED
DVT prevention	WRITTEN DISCUSSED
Safe sex and contraception	WRITTEN DISCUSSED
HIV/Hepatitis B	WRITTEN DISCUSSED
Fit for travel web address	WRITTEN DISCUSSED
Advice re: Boosters	WRITTEN DISCUSSED
Malaria tablets	WRITTEN DISCUSSED
Other, please specify;	WRITTEN DISCUSSED

CHEMOPROPHYLAXIS RECOMMENDED	
Chloroquine (patient to buy OTC)	
Proguanil (patient to buy OTC)	
Doxycycline	
Malarone	
Mefloquine	
Emergency standby treatment	YES NO
Side effects discussed	YES NO
Private prescription requested	YES NO

Assessor's signature…… Date…….