Assessment of your travel needs

Please provide the information requested. This will enable us to tailor advice to fit your travel plans and your medical history

The Health Station

Personal Information

Surname		**First name**		**Title**	
Address					
Postcode		**Email Address**			
DOB		**Age**			
Home Tel		**Mobile Tel:**			
Occupation		**GP Name & Address**			

Travel plan

Countries to be visited	**Date of departure**	**Date of return**	**Business**	**Hotel**	**Cruise**	**Altitude**	**Family & Relatives**	**Tent**	**Backpack**

Your Health

Please tell us of any medical conditions which have affected you	**Please list any prescribed medication which you are taking**

Previous vaccinations

Have you ever had any of the following vaccinations or malaria tablets. If so, when?					
Tetanus		**Polio**		**Diphtheria**	
Typhoid		**Hepatitis A**		**Hepatitis B**	
Meningitis		**Yellow fever**		**Influenza**	
Rabies		**Jap B Enceph**		**Tick borne virus**	
Others					

Malaria Tablets	

During your consultation with the nurse, we will ask you to sign the following consent:

- *The information provided is correct to the best of my knowledge.*
- *I have had the opportunity to ask questions.*
- *I consent to the receiving the treatment recommended for me.*
- *`I have no reason to think I may be pregnant*

Signed

Date

Nurse Travel Risk Assessment

THS Number	
Date	

Consideration of Potential Issues

Issue		Plan
Medication review	p	
Allergy to egg or latex	p	
Previous vaccine reaction	p	
Other	p	

Issue		Plan
Patient or family have epilepsy or mental illness	p	
Recent DXR, chemo or steroids	p	
Pregnant, planning or lactating	p	
	p	

Travax consulted [_] Recommendations made:

Vaccines:	
Malaria:	
Other issues:	

A

General issues	
Food and water	
Sun safety	
Repellents	
Sexual health	
Insurance	
Unlicensed drugs	

B

Illnesses and vaccines	
Malaria	
Hepatitis A	
Hepatitis B	
Japanese Encephalitis	
Polio / Tet / Diphtheria	
Tick borne encephalitis	
Rabies	

C

Information resources	
Travel leaflets	
DVT	
Insurance	

Record of treatment provided

Date	Time	Vaccine	Brand	Batch	Expiry	Route	Deltoid L/R	Signed
Personal vaccination record completed and provided								

Note any follow up plans: