Asquith Surgery, 693 Welford Road, Leicester, LE2 6FQ,

t. 0116 323 2000

**Personal details**

|  |  |  |
| --- | --- | --- |
| Name: | | D.O.B:  Male / Female (delete as appropriate) |
| Easiest contact telephone number: | |  |
| Date of departure: | |  |
| Return date: |  |  |
| **Country/ Countries to be visited** | **Length of stay** | **Will you be away from medical help at your destination? If so, how remote?** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

Please tick [ ] the following:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Type of trip** | Business |  | Pleasure |  | Other |  |
| 1. **Holiday type** | Package |  | Self organised |  | Backpacking |  |
|  | Camping |  | Cruise ship |  | Trekking |  |
| 1. **Accommodation** | Hotel |  | Relatives/family home |  | Other |  |
| 1. **Travelling** | Alone |  | With family/friend |  | In a group |  |
| 1. **Staying in area which is…** | Urban |  | Rural |  | Altitude |  |
| 1. **Planned activities** | Safari |  | Adventure |  | Other |  |
| Do you have any allergies? For example, to eggs, antibiotics, nuts? | | | | | | |
| Have you ever had a serious reaction to a vaccine given to you before? | | | | | | |
| Does having an injection make you feel faint? | | | | | | |
| Do you or any close family members have epilepsy? | | | | | | |
| Do you have any history of mental illness? Including depression or anxiety? | | | | | | |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | | | | | | |
| **Women only**: Are you pregnant / planning pregnancy/ or breastfeeding? | | | | | | |

**Vaccination history**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Have you ever had any of the following vaccinations or malaria tablets?** | | | | | |
| Tetanus |  | Polio |  | Diptheria |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | Tick Borne |  |
| Other: | | | | | |
| Malaria tablets: | | | | | |

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

**I have no reason to think that I might be pregnant. 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.**

**Signed:**…………………………………………………………… **Date**:…………………………………

**PRINT NAME**:……………………………………………………

|  |
| --- |
| FOR OFFICIAL USE ONLY |
| Patient Name: |
| Travel risk assessment performed: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Disease Protection** | **In Date** | **Required** | **Further information** |
| Hepatitis A |  |  |  |
| Hepatitis B |  |  |  |
| Typhoid |  |  |  |
| Cholera |  |  |  |
| Tetanus |  |  |  |
| Diptheria |  |  |  |
| Polio |  |  |  |
| Meningitis ACWY |  |  |  |
| Yellow Fever |  |  |  |
| Rabies |  |  |  |
| Japanese B Encephalitis |  |  |  |
| Other |  |  |  |

|  |  |  |
| --- | --- | --- |
| Signed by: | Position: | Date: |

This surgery is within the NHS Leicester City area