**Reddish Family Surgery**

**Travel form – Before your appointment**

**Please bring the completed form into clinic so a nurse can check what vaccines are needed and an appointment can be made. Please note an appointment will only be given once the completed form is received and reviewed. If the travel form is handed in less than 6 weeks before travel, we CANNOT guarantee an appointment.**

**Thanks, Sr Khan**

**PLEASE VISIT** – [www.travelhealthpro.org](http://www.travelhealthpro.org) this website will provide you with up-to-date advice & current recommendations for all travel.

**This surgery can only provide vaccinations that are available on the NHS; Any private vaccines will have to obtained from a travel clinic.**

**The NHS available vaccines are:**

Hepatitis A

Tetanus

Polio

Typhoid

Malaria tablets & all other vaccinations are available privately from a local travel clinic or within local pharmacies.

If you are travelling to more than 1 country, please attend a private travel clinic for more specialist advice.

**WE DO NOT ISSUE: Yellow Fever certificates & Meningitis ACWY is not available on the NHS.**

Prevention of Malaria involves several steps; **these steps can be remembered as the A, B, C, D of Malaria prevention:**

**A**wareness of the risk

**B**ite prevention (particularly at nighttime)

**C**hemoprophylaxis (use of appropriate malaria prevention tablets)

**D**iagnosis (prompt diagnosis and treatment)

**Useful Websites** – Rabies bite treatment – [www.lamat.org](http://www.lamat.org) & [www.istm.org](http://www.istm.org)

DATE HANDED IN:

DATE RECEIVED BY NURSE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL DETAILS** | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | | | | **M/F** | | | | | |
| **Contact Number:** | | | | | | | | | | **Date of Birth:** | | | | | |
| **TRIP DETAILS** | | | | | | | | | |  | | | | | |
| **Date of Departure:** | | | | | | | | | | **Length of stay overall:** | | | | | |
| **Date of Return:** | | | | | | | | | |
| **DESTINATION (S)** | | | | | | | | | | | | | | | |
| **Countries to be visited** | | | **Areas staying within Country** | | | | | | | | | | **Length of stay** | | |
| 1. | | |  | | | | | | | | | |  | | |
| 2. | | |  | | | | | | | | | |  | | |
| 3. | | |  | | | | | | | | | |  | | |
| 4. | | |  | | | | | | | | | |  | | |
| **Are any of these areas remote or away from medical help?** | | | | | | **YES** | | | | | | | **NO** | | |
|
| **Do you plan to travel abroad again in the future?** | | | | | | **YES** | | | | | | | **NO** | | |
|  | | | | | | |  | | |
| **DESCRIBE YOUR TRIP** | | | | | | | | | | | | | | | |
| **Type of trip?** | Business |  | | Pleasure | | | |  | Visiting Relatives | | |  | | Other |  |
| **Holiday type?** | Package Tour |  | | Camping/Backpacking | | | |  | Cruise | | |  | | Touring |  |
| **Accommodation** | Hotel |  | | Relatives Home | | | |  | Cruise Ship | | |  | | Other |  |
| **Travelling** | Alone |  | | With family/friends | | | |  | In a group | | |  | | Supervised Tour |  |
| **Staying** | Urban Area |  | | Rural Area | | | |  | At Altitude | | |  | | Backpacking |  |
| **Planned activities** | Safari |  | | Activity Holiday | | | |  | Other | | |  | | | |
| **PREVIOUS/CURRENT MEDICAL HISTORY** | | | | | | | | | | | | | | | |
| ------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------ | | | | | | | | | | | | | | | |
| **CURRENT MEDICATION** | | | | | | | | | | | | | | | |
| ---------------------------------------------------------------------------------------------------------------------- | | | | | | | | | | | | | | | |
| **PREVIOUS REACTIONS TO ANY VACCINES** | | | | | | | | | | | | | | | |
| --------------------------------------------------------------------------------------------------------------------- | | | | | | | | | | | | | | | |
| **HAVE YOU HAD ANY OF THE FOLLOWING?** | | | | | | | **YES** | | | | | | **NO** | | |
| RADIOTHERAPY | | | | | | |  | | | | | |  | | |
| CHEMOTHRAPY | | | | | | |  | | | | | |  | | |
| STERIOD TREATMENT | | | | | | |  | | | | | |  | | |
| IMMUNO SUPPRESENT TREATEMENT | | | | | | |  | | | | | |  | | |
| **WOMEN ONLY** | | | | | | | | | | | | | | | |
| **Are you?** | | | | | YES | | | | | | NO | | | | |
| PREGNANT | | | | |  | | | | | |  | | | | |
| PLANNING A PREGNANCY | | | | |  | | | | | |  | | | | |
| BREASTFEEDING | | | | |  | | | | | |  | | | | |
| **MEDICAL INUSURANCE ARRANGED?** | | | | | | | **YES** | | | | | | **NO** | | |
|  | | | | | | |  | | | | | |  | | |

|  |
| --- |
| **DECLARATION** |
| Based on the above information I consent to having vaccines as recommended by my health professional and declare all the information I have provided is true. I consent to any recommended vaccines being given.  Signature (Partner or Guardian if under the 16 years old )  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**CLINICAL STAFF TO COMPLETE**

|  |  |  |
| --- | --- | --- |
| **TRAVEL VACCINES RECOMMENDED FOR THIS TRIP AVAILABLE ON NHS** | | |
|  | **Y/N** | **COMMENTS** |
| **HEPATITIS A** |  |  |
| **TYPHOID** |  |  |
| **TETANUS, DIPTHERIA& POLIO** |  |  |

|  |  |  |
| --- | --- | --- |
| **PRIVATE TRAVEL VACCINES (To be assessed and administered at Private Travel Clinic)** | | |
|  | **Y/N** |
| **HEPATITIS B** |  |
| **MENINGITIS ACWY** |  |
| **CHOLERA** |  |
| **RABIES** |  |
| **JAP B ENC** |  |
| **YELLOW FEVER** |  |
| **OTHER** |  |

|  |  |
| --- | --- |
| **TO BE OBTAINED FROM PHARMACY** | |
|  | **COMMENTS** |
| **JUNGLE FORMULA** |  |
| **MALARIA TABLETS RECOMMENDED** |  |
| **OTHER** |  |

**FORM REVIEWED BY:**

**SIGN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**