Dear Patient

North Chelmsford Healthcare Centre provides NHS-funded travel vaccines **only** which are:

* Typhoid
* Hepatitis A
* Polio
* Cholera
* MMR

Please complete one travel form per family member travelling and ensure all areas on the form have been completed.

Once we receive your completed travel form at the practice, we will send you a link to the travel website where you can look up which travel vaccines you need for your destination. <http://travelhealthpro.org.uk>

The nurse will telephone you within 2 weeks to go over your completed travel form/s. If the nurse assesses that you need travel vaccinations, an appointment will be made in 6-8 weeks from the time you handed your form/s into reception. **If you need an appointment quicker than this, please go to your nearest travel clinic.**

Thank you.

North Chelmsford Healthcare Centre

For Office Use Only at point of returning completed forms:

Telephone appointment booked by Receptionist

Front letter to be returned to Patient

**TRAVEL RISK ASSESSMENT FORM** – ideally to be completed by traveller prior to appointment

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | Your country of origin: | |
| Date of Birth: | |
| Male Female Non-binary | |
| E mail: | | Telephone Number:  Mobile Number: | |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW** | | | |
| Date of departure: | | Total length of trip: | |
| **COUNTRY TO BE VISITED** | **EXACT LOCATION OR REGION** | **CITY OR RURAL** | **LENGTH OF STAY** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| What modes of transport will you be using?  Have you taken out travel insurance for this trip?  Do you plan to travel abroad again in the future? | | | |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY** | | | |
| Holiday  Business trip  Expatriate  Volunteer work  Healthcare worker | Staying in hotel  Cruise ship trip  Safari  Pilgrimage  Medical Tourism | Backpacking  Camping/hostels  Adventure  Diving  Visiting friends/family | Additional Information |

|  |  |  |  |
| --- | --- | --- | --- |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | |
|  | **YES** | **NO** | **DETAILS** |
| Are you fit and well today |  |  |  |
| Any allergies including food, latex, medication |  |  |  |
| Have you, or anyone in your family, had a severe reaction to a vaccine or malaria medication before? |  |  |  |
| Tendency to faint with injections |  |  |  |
| Any surgical operations in the past, including eg, open-heart surgery, spleen or thymus gland removal? |  |  |  |
| Recent chemotherapy/radiotherapy/organ transplant |  |  |  |
| Anaemia |  |  |  |
| Bleeding / clotting disorders (including history of DVT) |  |  |  |
| Heart disease (Eg, angina, high blood pressure) |  |  |  |
| Diabetes |  |  |  |
| Additional needs and/or disability |  |  |  |
| Epilepsy/seizures (or in a first degree relative?) |  |  |  |
| Gastrointestinal (stomach) complaints |  |  |  |
| Liver and or kidney problems |  |  |  |
| HIV/AIDS |  |  |  |
| Immune system condition eg, blood cancer |  |  |  |
| Mental health issues (including, anxiety, depression) |  |  |  |
| Neurological (nervous system) illness |  |  |  |
| Respiratory (lung) disease |  |  |  |
| Rheumatology (joint) conditions |  |  |  |
| Spleen problems |  |  |  |
| Any other conditions? |  |  |  |
| Are you or your partner pregnant or planning a pregnancy? |  |  |  |
| Are you breast feeding (if applicable) |  |  |  |
| Have you or anyone in your family undergone FGM / been cut / circumcised |  |  |  |

|  |
| --- |
| **Are you currently taking any medication (including prescribed, purchase or a contraceptive pill)?** |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** | | | | | |
| Tetanus/polio/diphtheria |  | MMR |  | Influenza |  |
| Typhoid |  | Hepatitis A |  | Pneumococcal |  |
| Chloera |  | Hepatitis B |  | Meningitis |  |
| Rabies |  | Japanese encephalitis |  | Tick borne encephalitis |  |
| Yellow fever |  | BCG |  | Other | |
| COVID-19 (dates, brand etc.) | | | | | |
| Malaria Tablets | | | | | |

|  |
| --- |
| **Any additional information:** |

For office use only:

|  |  |
| --- | --- |
| **Appointment Date Given:** |  |

*Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below. 1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine. RCN, London. 2. Field VK, Ford L, Hill DR, eds. (2010) Health Information for Overseas Travel. National Travel Health Network and Centre, London, UK. Form devised and created by Jane Chiodini © updated 2022*