King Cross Surgery Travel Risk Assessment Form

Name: Address: **DATE OF TRAVEL:**	Date of Birth: Male : Female: Mobile Number: Landline Number: Preferred Contact Method **Text or Telephone**

PLEASE COMPLETE THIS FORM IN DETAIL. Including SPECIFIC locations to be visited.

COUNTRIES TO BE VISITED	EXACT LOCATION OR REGION	CITY OR RURAL	LENGTH OF STAY
1.			
2.			
3.			

Have you taken out Travel Insurance?
Do you plan to travel aboard again within the next 6 months? If so where?

Trip type please tick ALL that apply:- **Additional Trip Info:-**

- Holiday - Staying in hotel - Backpacking
- Business - Cruise ship trip - Camping/Hostel
- Expatriate - Safari - Adventure
- Volunteer Work - Pilgrimage - Diving
- Healthcare worker - Medical Tourism - Visiting friends/family.

Please supply details of medical history & current medications			
	YES	**NO**	**DETAILS/MEDICATION**
Are you fit and well			
Allergies including food, latex and medication			
Severe reaction to vaccine before			
Tendency to faint with injections			
Any operations in the past including, splenectomy Or Thymus gland removed			
Recent Chemo/Radiotherapy/Organ transplant/Steroid treatment			
Anaemia			
Bleeding or clotting disorders (inc history of DVT)			
Heart disease and or High BP			
Diabetes			
Disability			
Epilepsy/Seizures (including close family history)			
Gastrointestinal (stomach) complaints			
Liver and or kidney problems			
HIV/AIDS			
Immune system condition			

Mental health issues including anxiety and depression			
Neurological (nervous system) illness **Please supply details of medical history & current medications**			
	YES	**NO**	**DETAILS/MEDICATION**
Respiratory (Lung) disease			
Rheumatology (Joint) problems			
Spleen problems			
Any other conditions requiring medication prescribed/purchased/contraception?			
Women Only			
Are you pregnant?			
Are you breastfeeding?			
Are you planning pregnancy during or sooner after your trip?			

Any additional information?

Attached for your information are 'Top Tips Travel Advice' and 'Vaccine Preventable Diseases' information leaflets. Please read and carefully consider the information as it will be discussed when you attend for any required immunisations. Then keep these in a safe place for future reference.

The information I have given is, to the best of my knowledge correct.

Patient signature:

Date:

For Surgery Use Only: Recommended Vaccinations & Potential Risks

Tetanus/Diptheria/Polio	Men ACWY	Schistosomiasis	Polio Certificate
Typhoid	Yellow Fever	Dengue Fever	Malaria Risk
Hep A	MMR	Japanese Encephalitis	Flu
Hep B	TB	Zika Virus	MERS-CoV
Rabies	Cholera	Tick Borne Encephalitis	VFF VTE

ADMIN ONLY:- Please ensure form is filled in correctly and correct contact details entered.

If multiple forms handed in, preferred person to contact is _____

Date Form Rec'd _____ Form Rec'd By _____ Date of Travel _____

Date Added to Travel Sheet _____ Risk Assessment Completed: Nurse _____

Date _____