

## WASHWAY ROAD MEDICAL CENTRE TRAVEL RISK ASSESSMENT FORM

Please complete one form per traveler. Return the form to reception or email to [admin.wrmc@nhs.net](mailto:admin.wrmc@nhs.net) at least 4 -6 weeks before travel, so we can stock & administer the vaccine(s) & give time for them to work.

Once we have reviewed your form we will message you with an appointment to see our nurse, giving enough time for you to complete your course of vaccinations prior to departure. Please note that certain travel services are not covered by the NHS so charges will apply. Our current fees are on our website [www.wrmc.org.uk](http://www.wrmc.org.uk) & displayed at reception. Prior payment in cash is needed per vaccination & a receipt will be issued. We will not administer non-NHS vaccines without sight of this receipt.

Patient's name:		Date of birth:	Weight ( if under 13 yrs)
		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Address:		E mail:	
		Mobile no:	
		Additional contact no:	
<b>PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW</b>			
Date of departure:		Total length of trip:	
<b>COUNTRY TO BE VISITED</b>	<b>EXACT LOCATION OR REGION</b>	<b>CITY OR RURAL</b>	<b>LENGTH OF STAY</b>
1.			
2.			
3.			
Do you plan to travel abroad again in the future?			
<b>TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY</b>			
Type of Trip	<input type="checkbox"/> Holiday <input type="checkbox"/> Business trip <input type="checkbox"/> Medical tourism <input type="checkbox"/> Pilgrimage <input type="checkbox"/> Visiting friends/family <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Volunteer work		
Holiday Type	<input type="checkbox"/> Staying in hotel <input type="checkbox"/> Backpacking <input type="checkbox"/> Cruise ship trip <input type="checkbox"/> Camping/hostels <input type="checkbox"/> Relatives/Family home		
Travelling	<input type="checkbox"/> Alone <input type="checkbox"/> With friends/family <input type="checkbox"/> in a group <input type="checkbox"/> Expatriate		
Planned Activities	<input type="checkbox"/> Safari <input type="checkbox"/> Adventure <input type="checkbox"/> Diving		
Additional Information			
<b>PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY</b>			
	<b>YES</b>	<b>NO</b>	<b>DETAILS</b>
Any allergies including food, latex, medication			
Severe reaction to a vaccine before			
Any surgical operations in the past, including e.g. your spleen or thymus gland removed			
Recent chemotherapy/radiotherapy/organ transplant			
Anaemia			

	YES	NO	DETAILS
Bleeding /clotting disorders (including history of DVT)			
Heart disease (e.g. angina, high blood pressure)			
Diabetes			
Disability			
Epilepsy/seizures			
Gastrointestinal (stomach) complaints			
Liver and or kidney problems			
HIV/AIDS			
Immune system condition			
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
<b>Any other conditions?</b>			
<b>Women only</b>			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			

**PLEASE LIST ALL CURRENT MEDICATIONS** (including prescribed, purchased or a contraceptive pill) or state if none being taken:

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**PLEASE SUPPLY DATES OF ANY VACCINES GIVEN OR MALARIA TABLETS TAKEN IN THE PAST** [you may need to contact the service provider to check dates]

Yellow fever		MMR		Tetanus/polio/diphtheria	
Typhoid		Hepatitis A		Japanese Encephalitis	
Cholera		Hepatitis B		Tick Borne Encephalitis	
Pneumococcal		Meningitis		Malaria Tablets	
Rabies		BCG		Other	

1. Have you submitted forms for your partner or other household members for this trip? Yes/No  
 If yes, we will try to see you all at the same appointment, please specify if you **do not** want to be seen at the same time as your partner/family member(s).

2. Are you happy for us to send one text/letter/email for correspondence? Yes/No

Form completed by: ..... Signature: ..... Date: .....

<b>For Office Use Only</b>		
Date form received:	Admin name:	
Date nurse reviewed:	Nurse signature:	
Allocated appt date & time:	SMS/Email/Letter sent	Additional info given/sent