TRAVEL CONSULTATION RECORD (one form per traveller)

Personal Details		Nurse
Name:	Date of appointment:	
Date of birth:		
Easiest contact telephone number:		

Travel Details	
Destination Country/ies:	Type of accommodation:
Access to medical help at destination? :	How remote? :
Date of departure:	Duration of stay:

Important Information (e.g. past medical history, medication, allergies) - use overleaf if necessary
1. Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions, epilepsy, depression, anxiety)
2. List any current or repeat medications
3. Do you have any allergies? (e.g. nuts, eggs, antibiotics?)
4. Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
5. Women only: Are you pregnant or planning pregnancy or breast feeding?
6. Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?

Previous Vaccination History					
	Tick	Date		Tick	Date
Tetanus/Diphtheria/Polio			Meningitis		
Typhoid			Rabies		
Hepatitis A			Yellow Fever		
Hepatitis B			Malaria Tablets		
BCG			Other:		

FOR OFFICIAL USE

Recommended Vaccines							
	Tick	Date	Signature		Tick	Date	Signature
Meningitis				Tetanus			
Yellow Fever				Diphtheria			
Cholera				Polio			
Typhoid				Malaria Tablets			
Hepatitis A				Other:			
Hepatitis B		1.		2.	3.		
Rabies		1.		2.	3.		

Additional Comments / Advice		
□ Insect bite prevention □ Personal health/safety □ Insurance	□ Vaccine Record □ DVT/Long haul □ Sun and heat protection	□ Travax leaflet □ Food, water & personal hygiene / travel diarrhoea

Malaria prevention advice and malaria chemoprophylaxis			
Chloroquine and proguanil		Atovaquone & proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

I have discussed all of the above with the Practice Nurse and give my consent to have the recommended vaccinations.	
Signed:	Date: