

Travel Clinic Risk Assessment Form (tRAF)

Date: __ / __ / 20 __

Patient's personal details						
Title:	Mr:	Miss:	Ms:	Mrs:	Dr:	Patient address:
Name:						
Surname:						GP Name and address:
Email:						
Mobile:						Would you like your GP to be notified of this consultation?
Gender:	M:	F:	D.O.B: __ / __ / __			

Dates, itinerary and purpose of trip

Date of departure: _____ Return date or overall length: _____

Country to be visited	Length of stay	Remote? Trek? Medical access? Altitude?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Mode of transport: _____

Personal medical history

Tick which of the following applies to you	Yes	No	Details (reconfirmed at each appointment)
Are you feeling well today?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any immunisations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any recent or past medical history of note?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any current or repeat medicines or are you taking halofantrine?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any allergies to any medicines, latex or eggs?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a serious reaction to a vaccine, antimalarial or doxycycline before?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you know if you are hypersensitive to mefloquine or related compounds (e.g. quinine, quinidine) or excipients?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you or any of your family suffer from epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a past history of black water fever?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have severe impairment of liver function?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you suffer from any blood disorders such as thalassemia or sickle cell anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you recently undergone radiotherapy, chemotherapy, steroids treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any history of the following: anxiety, depression, heart, lung, spleen, liver, kidney, immunity, blood conditions, disorders, diabetes, immunity, HIV-AIDs?	<input type="checkbox"/>	<input type="checkbox"/>	

Vaccination history

Have you had a vaccine, antimalarial or doxycycline before? (Please add dates)

Dip Tet Polio	Typhoid	Hepatitis A
Hepatitis B	Meningitis	Yellow Fever
Rabies	Jap B Encephalitis	Influenza
Shingles	Meningitis B	Tick Borne Encephalitis
MMR	Chickenpox	
Other.....	Malaria Tablets.....	

Women only

Tick which of the following applies to you	Yes	No	Details (to be reconfirmed at each appointment)
Are you pregnant or planning a pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	

Please write below any further information which may be relevant e.g. medicines, conditions...

FOR OFFICIAL USE

Consultation Record		For each consultation add: date, batch No, expiry date, administration site and patient consent signature		
Vaccine	Consultation 1	Consultation 2	Consultation 3	Price
Dip / Tet / Polio				
Typhoid				
Hepatitis A				
Hepatitis B				
Meningitis				
Rabies				
Cholera				
Yellow Fever				
Other				
Other				
Malaria Oral Medicine	Date	Quantity	Details	Price
Atovaquone + Proguanil				
Lariam (mefloquine)				
Doxycycline				
Paludrine (chloroquine + proguanil)				
Chloroquine				

Total price.....

Additional travel advice:

Water and personal hygiene	<input type="checkbox"/>	Travellers' diarrhoea	<input type="checkbox"/>	Hepatitis B and HIV	<input type="checkbox"/>
Insect bite prevention	<input type="checkbox"/>	Animal bites	<input type="checkbox"/>	Accidents	<input type="checkbox"/>
Insurance	<input type="checkbox"/>	Air travel	<input type="checkbox"/>	Sun and heat protection	<input type="checkbox"/>

Notes:

PATIENT CONSENT

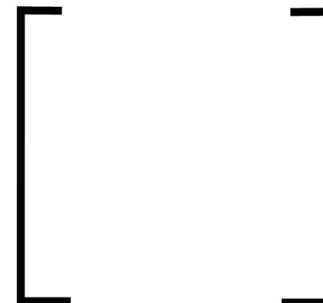
I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment.

Patient / Guardian signature..... / / Date.....

Pharmacist's signature..... / / Date.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? **Yes / No**

Clinic Stamp:



Date _____

Dear Doctor,

I have seen the following patient for a consultation and I have supplied and/or administered the following medicines. The patient has asked me to inform you that they would like these medicines entered into their centralized PMR system, which I believe is accessible at your surgery.

First Name of patient:	Surname of patient:	Gender (delete as appropriate) Male / Female
Date of Birth:	NHS No (if available):	GP Name:

Date	Medicine	Dose	Quantity	Batch no	Expiry	Admin site	Name of administering clinician	Consent obtained?
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>