Travel Risk Assessment Form

NAME:	
DATE OF BIRTH:	
CONTACT NUMBER:	
ADDRESS:	

Where / When are you going?			
Country	City / Town	Date of Travel	Length of Stay

Reason for Travel	
If you are new to the practice, please bring records your current medication and records you hold of previous travel injections / medication.	

(For **CLINICIAN** / **NURSE** to Complete)	
Travel Injections / Medication Needed?	Yes ☐ / No ☐ - (if **YES**, please tick below)
Hepatitis A	☐
Hepatitis B	☐
Typhoid	☐
DTaP (Diphtheria, Tetanus & Polio)	☐
Meningitis ACWY	☐
Yellow Fever	☐
Japanese B Encephalitis	☐
Rabies	☐
Cholera	☐
Malaria	☐
Other	☐ ……..

Appointment Booked?	Yes ☐ / No ☐
Date:	Time:
PLEASE SCAN THIS FORM INTO THE PATIENT'S RECORD AFTER YOU HAVE BOOKED THE APPOINTMENT	