**SUTTONS MEDICAL GROUP**

Thank you for taking the time to complete a travel questionnaire for your planned trip. We would like you to return this as soon as possible, ideally at least 6 – 8 weeks prior to travel so we can process it and ensure you get the vaccinations you need before you go. If you are travelling in less than 2 weeks you may be advised to attend a private travel clinic.

If you do not require any vaccinations for this trip, we will let you know.

Please read the enclosed information sheets on the most common risks faced when travelling abroad and precautions that you can take to help you stay healthy.

Before you attend your appointment please check the website [www.fitfortravel.nhs.uk](http://www.fitfortravel.nhs.uk) which will give you information on vaccines required and current health risks in the country you are visiting.  
It is also worth checking the Foreign and Commonwealth website for further information at; <https://www.gov.uk/government/organisations/foreign-commonwealth-office>

Travel health consultations are provided free to our patients on the NHS as an additional service.

**However if you book an appointment and then DO NOT ATTEND YOU WILL BE INVOICED A CHARGE FOR THE APPOINTMENT TIME WASTED.**

Please cancel any appointments that you cannot attend giving plenty of notice and reschedule at a convenient time.

**PRIVATE TRAVEL CLINICS**

|  |  |
| --- | --- |
| MASTA – Peterborough The New Queen Street Surgery Syers Lane Whittlesey PE7 1AT Tel; 0330 100 4284 | MASTA – North Lincs 30 Church St Hasey Lincs DN9 2HY Tel; 0330 100 4189 |

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| --- | --- | --- | --- |
| **Personal Details** | | | |
| Name | | Date of birth Male [ ] Female [ ] | |
| Easiest contact telephone number  Email | |  | |
| **Dates of trip** | | | |
| Date of departure | |  | |
| Return date or overall length of trip | |  | |
| Details about destination(s) | | | |
| Country and location to be visited | Length of stay | | Away from medical help at destination, if so, how remote? |
| 1 |  | |  |
| 2 |  | |  |
| 3 |  | |  |
| Do you plan to travel abroad again in the future? | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please tick as appropriate below to best describe your trip** | | | | | | |
| 1 .Type of trip | Business |  | Pleasure |  | Other |  |
| 2 Holiday Type | Package |  | Self organised |  | Backpacking |  |
| Camping |  | Cruise ship |  | Trekking |  |
| 3 Accomodation | Hotel |  | Relatives/family home |  | Other |  |
| 4 Travelling | Along |  | With family/friend |  | In a group |  |
| 5 Staying in area which is | Urban |  | Rural |  | Altitude |  |
| 6 Planned activities | Safari |  | Adventure |  | Other |  |

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| **Personal medical history** |
| Do you have any recent or past medical history of note?? (including diabetes, heart or lung conditions) |
| List any current or repeat medications |
| Do you have any allergies for example to eggs, antibiotics, nuts or latex? |
| Have you ever had a serious reaction to a vaccine given to you before? |
| Does having an injection make you feel faint? |
| Do you or any close family members have epilepsy? |
| Do you have any history of mental illness including depression or anxiety? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |
| Women only: Are you pregnant or planning pregnancy or breastfeeding? |
| Have you taken out travel insurance if you have a medical condition, informed the insurance company about this? |
| Please write below any further information which may be relevant |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccination history** | | | | | |
| Have you ever had any of the following vaccinations/malaria tablets and if so when? | | | | | |
| Tetanus |  | Polio |  | Diphtheria |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | Tick Borne |  |
| Other | | | | | |
| Malaria Tablets | | | | | |

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed Date

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| **FOR OFFICIAL USE** |
| Patient Name: |
| Travel risk assessment performed Yes [ ] No [ ] |

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| --- | --- | --- | --- | --- |
| **Travel vaccines recommended for this trip** | | | | |
| Disease protection | Yes | No | Patient declined vaccine | Vaccine name, dose & schedule for PSD |
| Hepatitis A |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Typhoid |  |  |  |  |
| Cholera |  |  |  |  |
| Tetanus |  |  |  |  |
| Diphtheria |  |  |  |  |
| Polio |  |  |  |  |
| Meningitis ACWY |  |  |  |  |
| Yellow Fever |  |  |  |  |
| Rabies |  |  |  |  |
| Japanese B Encephalitis |  |  |  |  |
| Other |  |  |  |  |

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| **Travel advice and leaflets given as per travel protocol** | | | | | |
| Food, water and personal hygiene advice |  | Traveller’s diarrhoea |  | Blood and bodily fluid infection risks e.g. Hepatitis B |  |
| Insect bite prevention |  | Animal bites |  | Accidents |  |
| Insurance |  | Air travel |  | Sun and heat protection |  |
| Websites |  | SMS vaccines reminder service set up | | |  |
| Travel record card supplied |  | Other | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Malaria prevention advice and malaria chemoprophylaxis** | | | |
| Chloroquine and proguanil |  | Atovaquone + proguanil |  |
| Chloroquine |  | Mefloquine |  |
| Doxycycline |  | Malaria advice leaflet given |  |

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| **Further information** |
| e.g. weight of child |
| **Authorisation for Patient Specific Direction (PSD) Use** |
| Name: Signature: Date: |