STONEHAM LANE SURGERY

**NHS & Private Travel Risk Assessment Form**

Please complete this this form a **MINIMUM of 6 WEEKS PRIOR TO TRAVEL** to ensure that we have time to assess your travel needs and arrange an appointment for you. Alternatively you can attend a private travel clinic.

On receipt of the completed form the practice nurse who will assess your immunisation needs depending on your travel plans. The surgery will contact you to discuss this and will arrange a routine travel appointment here. Please be advised that Travel Appointments are not covered by the NHS and therefore will incur a fee payable prior to the immunisations being given, you will be advised of the costs when we contact you..

|  |
| --- |
| **Personal Details** |
| Your Full Name: | Date of Birth: | Male Or Female [ ] [ ] |
| Address:Postcode: | Home Tel No: | Mobile No: |
| GP Surgery: | GP Name: | GP Tel No: |
| **Personal Medical History:** |
| Do you have any recent or past medical history? (include diabetes, heart or lung conditions) |  |
| List any current or repeat medications……………… |  |
| Do you have any allergies for example to eggs, antibiotics, nuts? |  |
| Have you ever had a serious reaction to a vaccine given to you before? |  |
| 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 steroid treatment, radiotherapy or chemotherapy? |  |
| Women only. Are you pregnant, planning pregnancy or breast feeding? |  |
| Please inform us of any further information that may be relevant……………………………………….. |  |
| **Vaccination History, have you had any of the following vaccinations? If so, when?** |
| Tetanus | Polio | Hepatitis A | Rabies |
| Typhoid | Diphtheria | Hepatitis B | Jap B Enceph |
| Meningitis | Influenza | Yellow Fever | Tick Borne |
| Malaria tablets: | Other: |
| **Itinerary & Purpose of Visit:** |
| Country to be visited: | Departure & return Dates | Type of Trip:Business Or Pleasure | Accommodation:Hotel Or Self Catering |

|  |
| --- |
| **I consent to share this personal medical information with Stoneham Lane Surgery**  |
| Signature: | Print Name: | Date: |