

Travel Clinic Risk Assessment Form (tRAF) Form		Date:
<b>Patient's personal details</b>		
Title: Mr: <input type="checkbox"/> Miss: <input type="checkbox"/> Ms: <input type="checkbox"/> Mrs: <input type="checkbox"/> Dr: <input type="checkbox"/>	Patient Address:	
First Name:	NHS No. (if known):	
Last Name:	GP Name and Address:	
Telephone:	GP Telephone (if known):	
Gender: Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Would you like us to send a copy of this consultation to your GP? <input type="checkbox"/>	
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. _____	_____	_____
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? 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? Do you have a past history of black water fever? 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? 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	<input type="checkbox"/>	Typhoid	<input type="checkbox"/>	Hepatitis A
Hepatitis B	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Yellow Fever
Rabies	<input type="checkbox"/>	Jap B Encephalitis	<input type="checkbox"/>	Influenza
Shingles	<input type="checkbox"/>	Meningitis B	<input type="checkbox"/>	Tick Borne Encephalitis
MMR	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	Malarial Tablets
Other: _____				

Women only			
Tick which of the following applies to you	Yes	No	Details (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"/>	
<b>Please add any further information which may be</b>			

relevant e.g. Medicines,  
conditions...

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**FOR OFFICIAL USE**

<b>Consultation Record</b>		<b>For each consultation add:</b> date, batch No, expiry date, administration site and patient consent signature		
<b>Vaccine</b>	<b>Consultation 1</b>	<b>Consultation 2</b>	<b>Consultation 3</b>	<b>Price</b>
Dip / Tet / Polio				
Typhoid				
Hepatitis A				
Hepatitis B				
Meningitis				
Rabies				
Cholera				
Yellow Fever				
Other .....				
Other .....				

<b>Malaria Oral Medicine</b>	<b>Date</b>	<b>Quantity</b>	<b>Details</b>	<b>Price</b>
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**