Travel Consultation Record

For further information go to:

www.malariahotspots.co.uk
www.fco.gov.uk
www.fitfortravel.nhs.uk
www.nathnac.org

Name: _____

Date of Birth: _____ Age: _____ Sex: m/f

Travel Itinerary

Date of Departure _____

Destination(s) and duration of stay

_____

_____

_____

Type of holiday

Holiday/Business/VFR/Other details

_____

Accommodation

Hotel ____ Star / Hostel / Family home etc

_____

High Risk Activities
(eg. Winter sports, safari, climbing, water sports etc)

_____

_____

_____

Previous/Current Medical History
(e.g. asthma, diabetes, epilepsy, asplenic)

_____

_____

_____

_____

_____

Allergies to any drugs or Food

_____

_____

_____

Steroids: Y/N Contraceptive Pill: Y/N/NA
Pregnant: Y/N/NA Pregnancy Planned: Y/N
Well today?

_____

_____

Medical Insurance Arranged? Y/N

Previous Vaccination History

Previous Reaction to any vaccines Y/N
Feels Faint with Injection Y/N

Vaccination	Date rcvd
Tetanus	
Diptheria	
Polio	
Typhoid	
Hepatitis A 1st or Bst	
Hepatitis B 1st 2nd 3rd 4th	
Meningitis	
Yellow Fever	
Other	

Recommended Vaccines

Tetanus/diphtheria	
Polio	
Typhoid	
Hepatitis A	
Hepatitis B	
Meningitis A/C	
Yellow Fever	

Other

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: _____

Vaccine	Batch Number	Date Given	Site of Injection	Signed
Polio				
Tetanus			R L Arm Leg	
Tetanus/low dose Diptheria			R L Arm Leg	
Typhoid			R L Arm Leg	
Hepatitis A Vaccine 1st dose/booster			R L Arm Leg	
Hep A + Typhoid Hep A as1st dose or Hep A as booster			R L Arm Leg	
Meningitis AC/ACWY			R L Arm Leg	
Yellow Fever			R L Arm Leg	

Hepatitis B or Hepatitis A and B	1st dose date R L Arm Leg	2nd dose date R L Arm Leg	3rd dose date R L Arm Leg

General Advice Given: (tick box)

Food/water/sanitation ☐
Insect bites/animal bites ☐
Exposure to Sun ☐
Sexual behaviour ☐
Accident Prevention ☐
First Aid Kit ☐
Medication ☐
Insurance ☐

Travel Advice Given **Yes/No**
(as detailed in patient group direction)

Malaria Advice/Leaflet Given Yes/No
Malaria Chemoprophylaxis advised Yes/No

If child: Wt. _____ kg/recommended dose _____

Tablets Recommended

Mefloquine		Proguanil		Chloroquine	
Doxycycline		Malerone			

Travel record card given Yes/No/Updated

Signed _____
Practice Nurse

Signed _____
Doctor

Comments/Additional Vaccines