Travel Clinic Risk Assessment Form (tRAF) Blackwells Chemist, 245 Croydon Road, Beckenham

Patient's personal details	
Title: Mr: Miss: Ms: Mrs: Dr:	Patient address:
Name:	
Surname:	GP Name and address:
Email:	
Mobile:	Please inform the GP yourself so that your NHS records are updated ☐
D.O.B: _ _ / _ _ / _ _ Age……. … Weight of child……..	

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.		
5.		
6.		

Personal medical history

Tick which of the following applies to you	Yes	No	Details (reconfirmed at each appointment)
Are you feeling well today?	☐	☐	
Have you had any immunisations in the past 4 weeks?	☐	☐	
Do you have any recent or past medical history of note?	☐	☐	
Do you take any current or repeat medicines or are you taking halofantrine?	☐	☐	
Do you have any allergies to any medicines, latex or eggs?	☐	☐	
Have you had a serious reaction to a vaccine, antimalarial or doxycycline before?	☐	☐	
Do you known if you are hypersensitive to mefloquine or related compounds (e.g. quinine, quinidine) or excipients?	☐	☐	
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?	☐	☐	
Do you suffer from any blood disorders such as thalassemia or sickle cell anaemia?	☐	☐	
Have you recently undergone radiotherapy, chemotherapy, steroids treatment?	☐	☐	
Are you Pregnant, planning to be pregnant in the near future or breast feeding?	☐	☐	

Do you have any history of the following (Please Circle as relevant):
anxiety, depression, heart, lung, spleen, liver, kidney, thymus gland, immunity, blood conditions, disorders, diabetes, immunity, HIV-AIDs?

Vaccination History – OR Please Provide GP Vaccination Record Printout & Leave Below Blank

Have you had any of the below before? (Please add dates)

Dip Tet Polio	Typhoid	Hepatitis A
Hepatitis B	Meningitis ACWY	Yellow Fever
Rabies	Jap B Encephalitis	Influenza
Shingles	Meningitis B	Tick Borne Encephalitis
MMR	Chickenpox	Cholera
HPV	Pneumonia	Other (add below)

Other…….. Malaria Tablets……

Please write any further information which may be relevant e.g. medicines, conditions……

FOR OFFICIAL USE

Date of consultation						
Vaccine	**Consultation 1**	**Consultation 2**	**Consultation 3**	**Consultation 4**	**Consultation 5**	**Price**
Dip / Tetanus / Polio 40						
Typhoid 40						
Hepatitis A 65						
Hepatitis B 49						
Meningitis 60						
Rabies 85						
Cholera 85						
Yellow Fever 75						
Japanese Encephalitis 105						
Other						
TOTAL PAID						

Malaria Oral Medicine	**Date**	**Quantity**	**Details**	**Price**
Atovaquone + Proguanil **ADULT 3.50**			1 x daily	
Atovaquone + Proguanil **Paediatric 1.80**				
Doxycycline 100mg Capsules 65p			1 x daily	
Lariam (mefloquine) 4.50			1 x Weekly	

Additional travel advice:

Water and personal hygiene	☐	Travellers' diarrhoea	☐	Hepatitis B and HIV	☐
Insect bite prevention	☐	Animal bites	☐	Accidents	☐
Insurance	☐	Air travel	☐	Sun and heat protection	☐

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.....**Piyush Amin**.....**Date**.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? Yes / No