

## Appendix 2: Sample travel risk assessment and travel risk management forms

**Travel risk assessment (form A) – to be completed by traveller prior to appointment.**

Name:	Date of birth		
Address:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	Telephone number:		
Email:	Mobile number:		
<b>Please supply information about your trip in the sections below</b>			
Date of departure:	Total length of trip:		
<b>Country to be visited</b>	<b>Exact location or region</b>	<b>City or rural</b>	<b>Length of stay</b>
1.			
2.			
3.			
Have you taken out travel insurance for this trip?			
Do you plan to travel abroad again in the future?			
<b>Type of travel and purpose of trip – please tick all that apply</b>			
<input type="checkbox"/> Holiday	<input type="checkbox"/> Staying in hotel	<input type="checkbox"/> Backpacking	Additional information
<input type="checkbox"/> Business trip	<input type="checkbox"/> Cruise ship trip	<input type="checkbox"/> Camping/hostels	
<input type="checkbox"/> Expatriate	<input type="checkbox"/> Safari	<input type="checkbox"/> Adventure	
<input type="checkbox"/> Volunteer work	<input type="checkbox"/> Pilgrimage	<input type="checkbox"/> Diving	
<input type="checkbox"/> Healthcare worker	<input type="checkbox"/> Medical tourism	<input type="checkbox"/> Visiting friends/family	
<b>Please supply details of your personal medical history</b>			
	<b>Yes</b>	<b>No</b>	<b>Details</b>
Are you fit and well today			
Any allergies including food, latex, medication			
Severe reaction to a vaccine before			
Tendency to faint with injections			
Any surgical operations in the past, including e.g. your spleen or thymus gland removed			
Recent chemotherapy/radiotherapy/organ transplant			
Anaemia			
Bleeding /clotting disorders (including history of DVT)			
Heart disease (e.g. angina, high blood pressure)			
Diabetes			
Disability			
Epilepsy/seizures			
Gastrointestinal (stomach) complaints			
Liver and or kidney problems			
HIV/AIDS			
Immune system condition			

	Yes	No	Details
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
<b>Women only</b>			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			

<b>Are you currently taking any medication</b> (including prescribed, purchased or a contraceptive pill)?

<b>Please supply information on any vaccines or malaria tablets taken in the past</b>		
Tetanus/polio/diphtheria	MMR	Influenza
Typhoid	Hepatitis A	Pneumococcal
Cholera	Hepatitis B	Meningitis
Rabies	Japanese Encephalitis	Tick Borne Encephalitis
Yellow fever	BCG	Other
Malaria tablets		

Any additional information
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**Travel risk assessment form devised in conjunction with resources below.**

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine*. RCN, London. [www.rcn.org.uk](http://www.rcn.org.uk)
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK. [www.nathnac.org](http://www.nathnac.org)

## Travel risk management (form B)

For health professional use only in conjunction with travel risk assessment Form A					
Patient name:			Date of birth:		
Childhood immunisation history checked:					
Additional information:					
<b>National database consulted</b> for travel vaccines recommended for this trip and malaria chemoprophylaxis (if required):					
NaTHNaC:		TRAVAX:		Other:	
Disease protection advised	Yes	Disease protection advised	Yes	Malaria Chemoprophylaxis Recommendation	Yes
BCG/Mantoux		Influenza		Atovaquone/proguanil	
Cholera		Meningitis ACWY		Chloroquine only	
Dip/tetanus/polio		MMR		Chloroquine and proguanil	
Hepatitis A		Rabies		Doxycycline	
Hepatitis B		TBE		Mefloquine	
Hepatitis A+B		Typhoid		Proguanil only	
Hepatitis A + Typhoid		Yellow fever		Emergency standby	
Japanese Encephalitis		Other		Weight of child:	
Vaccine and General Travel Advice required/provided					
Potential side effects of vaccines discussed					
Patient Information Leaflet (PIL) from packaging or from <a href="http://www.medicines.org.uk/emc/">www.medicines.org.uk/emc/</a> given					
Patient consent for vaccination obtained: <input type="checkbox"/> verbal <input type="checkbox"/> written					
Post vaccination advice given: <input type="checkbox"/> verbal <input type="checkbox"/> written					
General travel advice leaflet given (all topics below in the surgery/clinic advice leaflet) and patient asked to read entire leaflet due to insufficient time to advise verbally on every topic:					Yes / No
Items ticked below indicate topics discussed specifically within the consultation:					
Prevention of accidents		Mosquito bite prevention			
Personal safety and security		Malaria prevention advice			
Food and water borne risks		Medical preparation			
Travellers' diarrhoea advice		Sun and heat advice			
Sexual health & blood borne virus risk		Journey/transport advice			
Rabies specific advice		Insurance advice			
<b>Other specific specialised advice / information given on:</b> e.g. smoking advice for a long haul flight; altitude advice; prevention of schistosomiasis etc.					
Source of advice used for further information: NaTHNaC TRAVAX Other					
<b>OR</b> no additional specialised advice given <input type="checkbox"/>					

**Additional patient management or advice taken following risk assessment – for example**

- Vaccine(s) patient declined following recommendation, and reason why
- Telephoned NaTHNaC or TRAVAX for advice or used Malaria Reference Laboratory fax service
- Contacted hospital consultant for specific information in respect of a complex medical condition
- Identified specific nature/purpose of VFR travel

**Authorisation for a Patient Specific Direction (PSD)**

Following the completion of a travel risk assessment, the below named vaccines may be administered under this PSD to

Name		Post vaccine records	
		Batch number	Site given
Name of Vaccine	Dose and schedule		RA LA
			RL LL
			RA LA
			RL LL
			RA LA
			RL LL
			RA LA
			RL LL
			RA LA
			RL LL
			RA LA
			RL LL

Signature of Prescriber	Date

**Post Vaccination administration**

Vaccine details recorded on patient computer record (vaccine name, batch no., stage, site, etc.)	Y / N
SMS vaccines reminder or post card reminder service set up	Y / N
Travel record card supplied or updated	Y / N
<b>Travel risk management consultation performed by:</b> (sign name and date)	