AQUA travel clinic

TRAVEL CLINIC RISK ASSESSMENT FORM (tRAF) **Date: _ _ / _ _ / 2 0 2 _**

PATIENT PERSONAL DETAILS

Title: Mr: Miss: Ms: Mrs: Dr:	Patient address:
Name:	
Surname:	
	GP Name and address:
Email:	
Mobile:	
Gender: M: F: D.O.B: _ _ / _ _ / _ _	

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.		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?	☐	☐	
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?	☐	☐	
Do you have any history of the following: anxiety, depression, heart, lung, spleen, liver, kidney, immunity, blood conditions, disorders, diabetes, immunity, HIV-AIDs?	☐	☐	

Vaccination history

Have you had a vaccine, antimalarial or doxycycline before? (PLEASE ADD DATES NEXT TO VACCINE TYPE)

Dip Tet Polio		Rabies		MMR		Hepatitis B
Typhoid		Yellow Fever		Shingles		Influenza
Hepatitis A		Jap B Encephalitis		Chickenpox		
Meningitis ACWY		Meningitis B		Tick Borne Encephalitis		

Other.. Malaria Tablets...

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.

	Consultation Date 1		**Consultation Date 2**		**Consultation Date 3**	
Patient Signature						
Pharmacist Signatur						

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OUR SERVICE IS A PRIVATE SERVICE AND NOT COVERED BY THE NHS

Do you consent to our pharmacy contacting you on other medical services we provide? **Yes / No**

Women only

Tick which of the following applies to you	Yes	No	Details (to be reconfirmed at each appointment)
Are you pregnant or planning a pregnancy?	☐	☐	
Are you breastfeeding?	☐	☐	

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

FOR OFFICIAL USE

Consultation Record

For each consultation add:

date, batch No, expiry date, administration site and patient consent signature

VACCINE	Consultation Date 1		Consultation Date 1		Consultation Date 1		Price
Dip / Tet / Polio	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Typhoid	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Hepatitis A	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Hepatitis B	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Yellow Fever	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Rabies	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Japanese Encephalitis	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Chickenpox	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	
Other	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	Batch Number AFFIX VACCINE STICKER	Expiry Date Site of Administration	

Malaria Oral Medicine	Date	Quantity	Details	Price
Atovaquone + Proguanil				
Lariam (mefloquine)				
Doxycycline				
Paludrine (chloroquine + proguanil)				
Chloroquine				

Total price..................

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: