If you are planning an overseas trip please print out and complete the *Details of Travel* form below and make an appointment with your Doctor to discuss your specific requirements.

Broadway Medical Centre Travel details form

Please Note: **CHARGES WILL APPLY** FOR ALL TRAVEL SERVICES

Eg: Prescription for Malaria tablets, vaccinations etc. Approximate costs etc can be requested from reception.

PLEASE GIVE 6 WEEKS NOTICE OTHERWISE YOU MAY NOT BE FULLY IMMUNISED AND WE MAY NOT HAVE AN APPOINTMENT AVAILABLE AT VERY SHORT NOTICE

Please print out and complete this form prior to your travel appointment with the Doctor

Name:	**M/F**	**Date of Birth:**
Address:		
Best Contact telephone number:		
Email address:		
Dates of trip:		
Date of departure:		
Return date or Overall length of trip		
INTINERARY AND PURPOSE OF VISIT:		
Country to be visited	**Length of stay**	**Away from medical help at destination? If so, how remote?**
1.		
2		
3		

Please circle the description that best describes your trip:

1. Type of trip	**Business**	**Pleasure**	**Other**
2. Holiday type	**Package/Camping**	**Self organized/cruise ship**	**Backpacking/Trekking**
3. Accommodation	**Hotel**	**Relatives/Family Home**	**Other**
4. Travelling	**Alone**	**With family/friend**	**In a group**
5. Staying in an area which is	**Urban**	**Rural**	**Altitude**
6. Planned Activities	**Safari**	**Adventure**	**Other**

PERSONAL MEDICAL HISTORY:
Do you have any recent or past medical history of note? This includes diabetes, heart or lung conditions, thymus disorder?

LIST ANY CURRENT MEDICATIONS	**DO YOU HAVE ANY ALLERGIES, IE EGGS, ANTIBIOTICS, NUTS?**

Have you ever had any serious reaction to a vaccine given to you before?
Does having an injection make you feel faint?
Do you or any close family members have epilepsy?
Do you have any history of mental illness or depression?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
WOMEN ONLY – Are you pregnant, planning a pregnancy or breastfeeding?
Have you taken out travel insurance? **If you have a medical condition have you informed the insurance company about this?**
Please give any further information that may be relevant:

VACCINATION HISTORY

Have you ever had any of the following vaccinations/malaria tablets, and if so when (Please Tick)

Tetanus	**Polio**	**Diptheria**
Typhoid	**Hepatitis A**	**Hepatitis B**
Meningitis	**Yellow Fever**	**Influenza**
Rabies	**Japanese B Encephalitis**	**Tick Borne**
Other		
Malaria Tablets		

<u>For discussion when risk assessment is performed within your appointment:</u>

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 I have had the opportunity to ask questions.
I consent to the vaccine/s being given.

Signed: _____ Date: _____

Office Use: Scanned to patient file?

CLINICAL USE

MEDICAL KIT	INITIAL	COMMENTS
ADVICE CHECK LIST		
FOOD/WATER		
INSECT AVOIDANCE		
DVT RISK/PREVENTION		
WOMENS HEALTH		
SEXUAL HEALTH		
PERSONAL SAFETY/INSURANCE		
DRUG INTERACTIONS		
ACTIVITY ADVICE		
Altitude		
Cycling		
Diving		
Rafting/Water		
Other		
DOCTORS SIGNATURE		
PRACTICE NURSE SIGNATURE		

MEDICAL NOTES

CLINICAL USE ONLY DATE:

DISEASE	VACCINE	V1	V2	V3
POLIO				
TET/DIPTHERIA				
MMR				
VARICELLA				
FLU				
PNEUMONIA				
TYPHOID				
HEP A				
HEP A & TYPHOID				
HEP B				
TWINRIX				
MENINGITIS ACWY				
YELLOW FEVER				
CHOLERA				
JAP ENCEPHALITIS				
RABIES				
BCG SCAR/NO SCAR				
MANTOUX				
MALARIA CHEMOPROPHYLAXIS DOXY LARIUM MALERONE CHOLOROQUINE				