

Patient's personal details							
Title:	Mr:	Miss:	Ms:	Mrs:	Mx:	Dr:	
Name:						Patient address:	
Surname:							
Email:							
Mobile:						GP Name and address:	
Gender:	Male	Female	Prefer not to say				Would you like your GP to be notified of this consultation? Yes No
Date of Birth:							

Dates, itinerary and purpose of trip

Date of departure:	Return date or overall length:					
Country or Countries to be visited	Length of stay	Purpose of visit?	Leisure?	Business?	Other?	
(If possible, be specific with cities or places)		Yes	No	Other details		
1.		Remote?				
2.		Trek?				
3.		Medical access?				
4.		Altitude?	Mode(s) 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 know 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 latest dates if known)

Diphtheria, Tetanus & Polio	Typhoid →	Hepatitis A →
↳	Meningitis ACWY →	Yellow Fever →
Rabies →	Japanese Encephalitis →	Influenza →
Shingles →	Meningitis B →	Tick Borne Encephalitis →
Hepatitis B →	Chickenpox →	Other →
Malaria Tablets →	MMR →	Other →

Women only

Tick which of the following applies to you	Yes	No	Details (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 1	Consultation 2	Consultation 3	Price
Dip / Tet / Polio				
Typhoid				
Hepatitis A				
Hepatitis B				
Meningitis				
Rabies				
Cholera				
Yellow Fever				
Other				
Other				
Malaria Oral Medicine	Date	Quantity	Details	Price
Atovaquone + Proguanil				
Lariam (mefloquine)				
Doxycycline				
Paludrine (chloroquine + proguanil)				
Chloroquine				

Additional travel advice:

Total price.....

Water and personal hygiene	<input type="checkbox"/>	Travellers' diarrhoea	<input type="checkbox"/>	Hepatitis B and HIV	<input type="checkbox"/>
Insect bite prevention	<input type="checkbox"/>	Animal bites	<input type="checkbox"/>	Accidents	<input type="checkbox"/>
Insurance	<input type="checkbox"/>	Air travel	<input type="checkbox"/>	Sun and heat protection	<input type="checkbox"/>

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..... / / Date.....

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