pharmadoctor

Patient Travel Consultation Details
Risk Assessment Form

Monkbar PHARMACY

Please complete first 3 pages and send to travel@monkbarpharmacy.co.uk

Title:		Sex:		Address:	
First Name:					
Surname:				City:	
Date of Birth:				Postcode:	
Telephone:				Country:	
Mobile:				Email:	

GP Name and Address:

Would you like your GP to be notified of this consultation? YES ◯ NO ◯

Vaccine history	Date		Vaccine history	Date

Destination countries/cities	Arrival Date	Departure Date

Reason for travel							
Hajj or other pilgrimage	☐		Visiting friends or relatives	☐		Altitude	☐
Other *(Please specify)*							

Medical information		
Y ◯	N ◯	Are you currently taking any medications (prescription or non-prescription)? *(if so please give details below)*
Y ◯	N ◯	Have you received oral or parenteral antibiotics within the last 14 days?
Y ◯	N ◯	Have you had a high fever or temperature in the last 24 hours? *(If yes, provide cause & length of fever?)*

Medical information – continued		
Y ◯	N ◯	Are you taking any regular medication which thins your blood or prevents it from clotting excluding aspirin 75mg? *(If yes, please provide more details)*
Y ◯	N ◯	Have you had past or recent surgery? *(If yes, please provide more details)*
Y ◯	N ◯	Are you pregnant, planning pregnancy, or is there any possibility that you could be pregnant? *(If yes, please provide more details)*
Y ◯	N ◯	Are you breast-feeding? *(If yes, please provide more details)*
Y ◯	N ◯	Do you have any ongoing medical problems? *(If yes, please provide more details)*
Y ◯	N ◯	Do you have any bleeding disorders? *(If yes, please provide more details)*
Y ◯	N ◯	Are you receiving dialysis?
Y ◯	N ◯	Have you been told you may have low immunity? *(If yes, please provide more details)*
Y ◯	N ◯	Does anyone in your family have a congenital or hereditary immune disorder?
Y ◯	N ◯	Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine?
Y ◯	N ◯	Have you had any allergies or severe reactions to previous vaccinations? (*If yes, list the vaccines)*
Y ◯	N ◯	Do you have any allergies (*e.g eggs, antibiotics, nuts, medications*)?
Y ◯	N ◯	Have you been told by your doctor you have an intolerance to any sugars, (e.g. galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption)?
Y ◯	N ◯	Do you suffer from thymus dysfunction? *(If yes, please provide more details)*
Y ◯	N ◯	Have you had your school leavers DTP vaccine? *(If yes or unsure, please provide details)*
Y ◯	N ◯	Do you have any cerebral disorders *(e.g. epilepsy or stroke)? (If yes, please provide more details)*
Y ◯	N ◯	Have you ever taken antimalarials before? (If yes, select all the antimalarials you have taken before.)
		Mefloquine (Lariam) ☐ | Doxycycline ☐ | Atovaquone/Proguanil (Malarone) ☐ | Chloroquine ☐ | Proguanil ☐ | Unsure ☐
Y ◯	N ◯	Have you have ever had problems taking any malaria medication before? *(If yes, please provide details)*

Medical information – continued		
Y ◯	N ◯	Have you had a serious liver problem requiring a liver specialist review? *(If yes, please provide details)*
Y ◯	N ◯	Have you had any serious kidney problems requiring a kidney specialist review? *(If yes, please provide full history of your kidney condition & any interventions of your kidney condition)*
Y ◯	N ◯	Have you had kidney failure due to malaria or Blackwater fever? *(If yes, please provide details)*
Y ◯	N ◯	Do you or any close family suffer from epilepsy?
Y ◯	N ◯	Have you ever suffered/do you currently suffer from any psychiatric problems? *(Please answer yes even if the episode was mild or an isolated case, and provide details below)*
	Anxiety ☐	Panic attacks ☐ Depression ☐ Any other psychiatric problems ☐
Y ◯	N ◯	Have you received any blood products such as antibodies (immunoglobulins) in the last 3 months?
Y ◯	N ◯	Are there any other health/medical details you feel we should know? (If yes, please provide details)

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 /carer signature..... /..... ..... /..... Date.....

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FOR OFFICIAL USE ONLY							
Further advice/documentation provided							
Water and personal hygiene	☐	Travellers' diarrhoea	☐	Hepatitis B and HIV	☐	Leaflets given including PILs	☐
Insect bite prevention	☐	Animal bites	☐	Accident avoidance	☐	Meningitis (ACWY) certificate given	☐
Insurance	☐	Air travel	☐	Sun and heat protection	☐	Yellow Fever certificate given	☐

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

For each vaccine add: Date, batch No, expiry date and administration site

Vaccine	Consultation 1	Consultation 2	Consultation 3	Price
Yellow fever				
Meningitis ACWY				
Typhoid				
Combined Hep A + Typhoid				
Combined Hep A + Hep B				
Hep A				
Hep B				
Tick-borne encephalitis				
Japanese encephalitis				
Rabies				
Cholera				
Mefloquine				
Doxycycline				
Atovaquone/ proguanil				
Dip / Tet / Polio				

Pharmacist's signature..... ...../..... ..... /..... Date.....