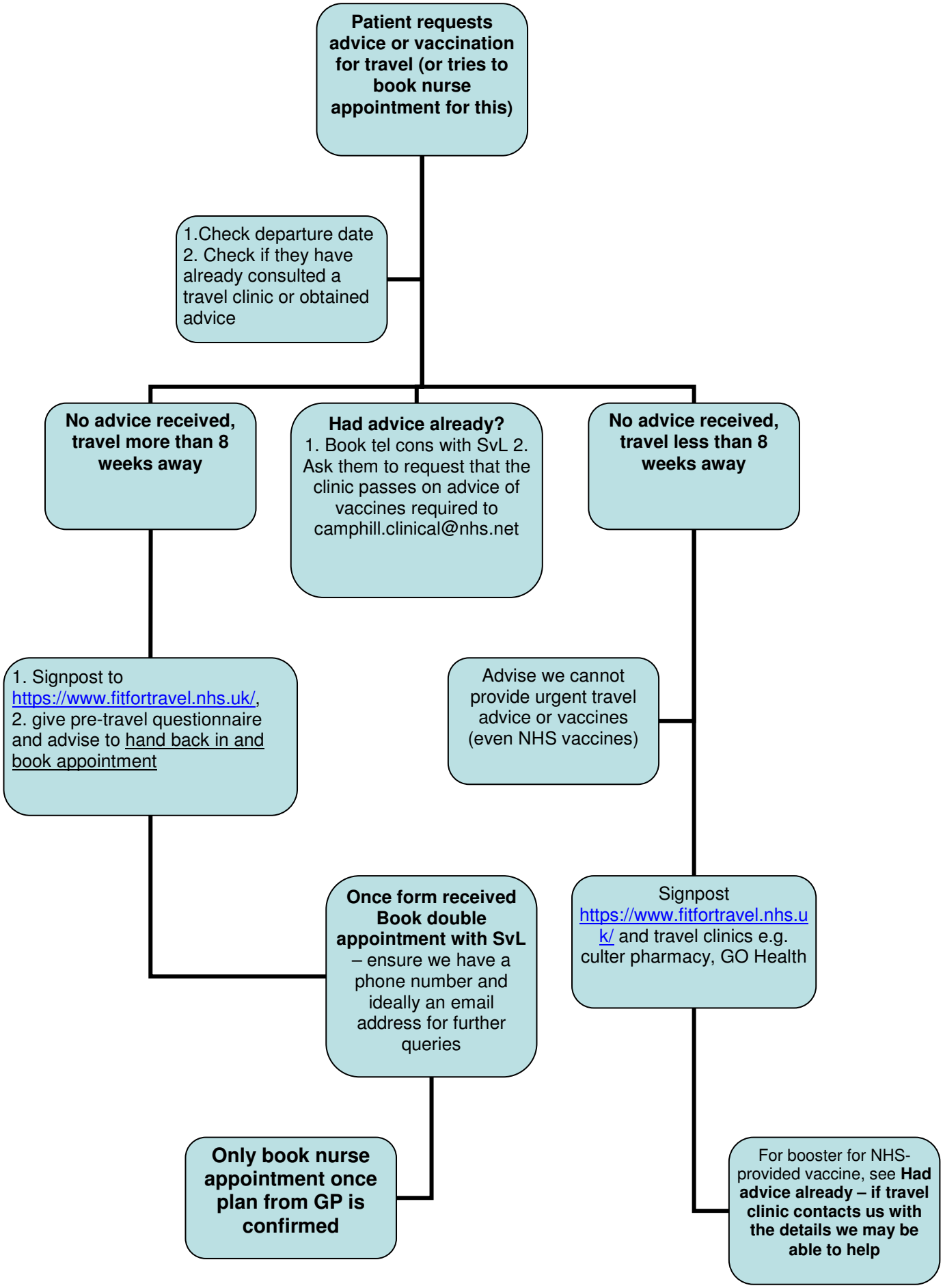
Camphill Medical Practice Travel Vaccination/Consultation Protocol

November 2019: prior to vaccination nurses taking over this service. With addendum re travel advice consultation.



Camphill Medical Practice Pre-Travel Patient Questionnaire

Surname _____

Forename _____

Tel No _____

Email address_____

Date of Birth _____

M/F _____ **Date** _____

Signature/Guardian _____

ADMIN ONLY: Date handed in:
Date of travel:
Clinician booked with:
Date of appointment:

1. What is your departure date?

_____

2. How long will you be away?

_____

3. Which countries do you intend to visit? (including brief stopovers)

_____
_____
_____
_____
_____
_____
_____

4. Will your journey take you to the:

- **Coast** ☐
- **Interior** ☐
- **Islands** ☐

5. Will you be staying in:

- **Tourist hotels** ☐
- **Relatives homes** ☐
- **Local accommodation** ☐
- **Camping** ☐

6. Are you travelling with:

- **Family** ☐
- **Partner** ☐
- **Alone** ☐
- **Group** ☐

7. Are you going on:

- **an organised package tour** ☐

8. Is your holiday for:

- **Pleasure** ☐
- **Business** ☐
- **For a period of voluntary service** ☐

9. Will you be interacting with animals, working with the local population, travelling in areas with poor communication, ascending above 2,500 metres, or participating in adventure sports?

Yes No
If yes, please give details

_____

_____

10. Will you be in areas where medical help is non-existent (even for a short period)?

Yes No
If yes, please give details

_____

_____

11. Are you suffering from any minor ailments?

Yes No
If yes, please give details

_____

_____

12. Do you have any long-term medical conditions?

Yes No
If yes, please give details

_____

_____

13. Do you have a history of epilepsy?

Yes No
If yes, please give details

_____

_____

14. **Have you ever experienced anxiety, depression or other psychological problems which have required treatment?**

Yes **No** **If yes, please give details**

_____

15. **Have you had your spleen removed?**

Yes **No** **If yes, please give details**

_____

16. **Have you ever had a bad reaction to a vaccine?**

Yes **No** **If yes, please give details**

_____

17. **Do you have any other allergies, eg eggs?**

Yes **No** **If yes, please give details**

_____

18. **Are you taking any medication including the oral contraceptive pill, or have you been on antibiotics witin the last 10 days?**

Yes **No** **If yes, please give details**

_____

_____

19. **Are you pregnant, breast-feeding or planning pregnancy?**

Yes **No** **If yes, please give details**

_____

20. **Have you ever tested positive for HIV? (This can affect the choice of vaccines given)**

Yes **No** **If yes, please give details**

_____

21. **Have you recently received treatment with radiotherapy, chemotherapy or steroids?**

Yes **No** **If yes, please give details**

_____

22. **Are any children who are travelling up to date with their childhood vaccinations?**

Yes **No** **If yes, please give details**

_____

23. **Have you previously had any vaccinations**

Yes **No** **If yes, please give details**

_____

24. **Have you had any of the following vaccinations and, if so, give date of course/last booster?**

Typhoid	**____**	**Meningitis**	**____**
Tetanus	**____**	**Japanese Encephalitis**	**____**
Polio	**____**	**Tick-borne Encephalitis**	**____**
Rabies	**____**	**Diptheria**	**____**
Hepatitis A	**____**	**Yellow Fever**	**____**
Hepatitis B	**____**		

Vaccination Schedule	1st Visit	2nd Visit	3rd Visit	4th Visit

Malaria Prophylaxis **Yes** ☐ **No** ☐
Product _____

Other advice given: **Sun protection** □ **Bite avoidance** □ **Medication storage/usage** □

Contraception □ **Water & food** □ **Personal safety advice** □ **Other advice** _____

Referred to Fit For Travel website □ **Referred to specialist clinic for altitude/yellow fever/other advice** □

I have been advised as documented above and understand the advice offered.

Patient/Parent/Guardian/Carer Signature: _____ Date: _____