Wadhurst Medical Group
(Incorporating Belmont & Ticehurst Surgeries)
St James's Square Wadhurst TN5 6BJ

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www.wadhurstmedicalgroup.co.uk

High Weald Lewes and Havens CCG

Title Given Name Surname
Home Full Address (stacked)

Dear Title Given Name

Re: Title Given Name Surname DOB: Date of Birth
NHS Number: NHS Number

Further to your recent request for travel vaccinations, we would be grateful if you could complete the Travel Risk Assessment form enclosed. The completed form must be returned to the Surgery no later than 5 days ahead of your appointment, this can be by hand or scanned in and e-mailed to hwlhccg.belmont@nhs.net this ensures that our Practice Nurses have all the correct information to hand.

Please note we reserve the right to refuse travel vaccinations if sufficient information is not provided.

Should you have any queries in the meantime, please do not hesitate to contact us.

Yours sincerely,

Julia Dann | Lead Nurse
Wadhurst Medical Group

Wadhurst Medical Group

Travel Risk Assessment Form and Information

To be completed for each traveller before travel appointment

Please note that only vaccines available on the NHS are given by the Practice all private vaccines must be obtained at a travel clinic. Malaria medication is not available on the NHS but private prescription can be arranged if needed.

Name:		**Date of Birth:**	
E-mail Address:		**Telephone Number:**	
Date of Departure:		**Mobile Number:**	
		Total length of trip:	

Countries to be Visited:	**Exact Location or Region:**	**City or Rural**	**Length of Stay**
1.			
2.			
3.			
4.			
5.			

Do you have travel insurance?	Yes ☐ No☐
Do you plan to travel abroad again in the future?	Yes ☐ No☐
Type of Trip (tick all that apply):	
Holiday ☐ Business Trip ☐ Gap Year Trip ☐ Volunteer Work ☐ Healthcare Worker ☐ Staying in Hotel/Villa/Apartment/Resort ☐ Medical Tourism ☐ Visiting / Friends / Family ☐	Cruise Ship Trip ☐ Safari ☐ Pilgrimage ☐ Backpacking ☐ Camping / Hostels ☐ Adventure ☐ Diving ☐ Other ☐ Please state……..

Your Current and Past Medical History – Please tick all that apply	
Heart disease / angina	Yes ☐ No☐
High blood pressure	Yes ☐ No☐
Diabetes	Yes ☐ No☐
Lung disease	Yes ☐ No☐
Epilepsy	Yes ☐ No☐
Liver or kidney disease	Yes ☐ No☐
Bleeding / clotting disorder	Yes ☐ No☐

Anaemia	Yes ☐ No☐
Disorders affecting your bowel or stomach	Yes ☐ No☐
Surgery particularly anything involving your spleen, thymus or open heart surgery	Yes ☐ No☐
Recent chemotherapy / radiotherapy (in the last 12months)	Yes ☐ No☐
Organ transplant	Yes ☐ No☐
Conditions which may lower your immune system	Yes ☐ No☐
HIV/AIDS	Yes ☐ No☐
Disorders of your nervous system	Yes ☐ No☐
Other spleen problems	Yes ☐ No☐
Are you under the care of a Rheumatologist	Yes ☐ No☐
Do you have now or in the past any mental health problems?	Yes ☐ No☐
Any other important information regarding your health not listed above:	Yes ☐ No☐
Do you have a tendency to faint with injections?	Yes ☐ No☐
Family History	
Any history of mental health problems in your family?	Yes ☐ No☐
Women only	
Are you pregnant?	Yes ☐ No☐
Are you currently breastfeeding?	Yes ☐ No☐
Are you currently using contraception? Please select any which apply	Pill / Coil / Implant / Injection / None
Men and Women	
Are you planning a pregnancy while you are away or shortly after your return?	Yes ☐ No☐
Children	
Is your child up to date with their UK childhood immunisations?	Yes ☐ No☐ Unsure ☐
Allergies / Reactions (Please tick all that apply)	
Food allergies	Yes ☐ No☐
Latex allergy	Yes ☐ No☐
Allergy or Reactions to medicines?	Yes ☐ No☐
Allergy to vaccines? Yes ☐ No☐ Please give details:……	

FORM 7 – Travel Risk Assessment

Medication	
Are you taking any other medication which does not appear on your NHS repeat prescription list? Please give details?	
Important Information	
Please bring to your consultation any records you hold of vaccinations or malaria tablets you may have had recently or in the past.	
Please continue here with any further details if not space above:	