

OFFICE USE ONLY	
Cleared by Travel Nurse	
Cleared by Manager	
Certificate Issued	

STUDENT ELECTIVE TRAVEL RISK ASSESSMENT
UEA Occupational Health Department

SECTIONS 1-3 TO BE COMPLETED BY STUDENT (in advance of appointment)

(1) PERSONAL DETAILS

Name:		E-mail:
DOB:		Contact Number(s):
Address:	Male / Female <i>(delete as applicable)</i>	GP Name & Address:

(2) ELECTIVE TRAVEL PLANS

Travelling to:	Date:	Describe location (rural/city/jungle...)
1.		
2.		
3.		

What do you plan to do on your elective/placement?

(3) ADDITIONAL TRAVEL PLANS

Do you plan on travelling anywhere either before or after your elective? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes - where? (please state all countries)
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SECTIONS 4-9 TO BE COMPLETED BY TRAVEL HEALTH NURSE

(4) MEDICAL HISTORY

Current:	Allergies:	FEMALE TRAVELLERS ONLY	
		Is there any risk of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient planning a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No LMP Date	
Previous:	Any Allergic Reaction to Egg or Gelatine: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Current Medication:	Any problem with vaccines? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(5) MALARIA PROPHYLAXIS

<input type="checkbox"/> Bite Avoidance <input type="checkbox"/> Repellents <input type="checkbox"/> Clothing <input type="checkbox"/> Nets <input type="checkbox"/> Prophylaxis <input type="checkbox"/> S/S Malaria	Previous Malaria Prophylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No Which Any Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	Script Issued Date: Issued by: Signature:	Does patient have a history of: <input type="checkbox"/> Epilepsy <input type="checkbox"/> Psoriasis <input type="checkbox"/> Kidney/Liver Problems <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Immunosuppression <input type="checkbox"/> Steroid Therapy <input type="checkbox"/> Anxiety/Depression
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(6) PSD AUTHORISATION STATEMENT

Following completion of the Travel Risk Assessment, I hereby authorise the use of the recommended vaccines below as a Patient Specific Direction (PSD).

Dr Name:

Dr Signature:

Date:

HIV Incidence in elective countries:

Possible contraindications to any vaccines/malaria prophylaxis:

Script Issued Date:

Issued by: Signature:

(7) IMMUNISATIONS

BCG date:	MMR dates:	Last DTP:	Hep B dates:	Comments
	1.		1.	
			2.	
	2.	Booster	3.	
			4.	

Consider	Required	Vaccine	Dates given previously	Date given in Travel clinic	Batch No. site and signature
<input type="checkbox"/>	<input type="checkbox"/>	BCG Vaccine			
<input type="checkbox"/>	<input type="checkbox"/>	DTP (Diphtheria, Tetanus, Polio)			
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A Primary/Booster			
<input type="checkbox"/>	<input type="checkbox"/>	Typhoid			
<input type="checkbox"/>	<input type="checkbox"/>	Meningitis ACWY			
<input type="checkbox"/>	<input type="checkbox"/>	Rabies 1 st			
<input type="checkbox"/>	<input type="checkbox"/>	Rabies 2 nd			
<input type="checkbox"/>	<input type="checkbox"/>	Rabies 3 rd			
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Fever			
<input type="checkbox"/>	<input type="checkbox"/>	Japanese Encephalitis 1 st			
<input type="checkbox"/>	<input type="checkbox"/>	Japanese Encephalitis 2 nd			
<input type="checkbox"/>	<input type="checkbox"/>	Others			

(8) VACCINATION SCHEDULE

		Additional Vaccines/Requirements/Notes:	

(9) COMMENTS/ADDITIONAL INFORMATION

Date:		Signed:
Date:		Signed:
Date:		Signed:
Date:		Signed:

PATIENT CONSENT
 I consent to this vaccine programme, and fully acknowledge that it is my responsibility to check on Rabies and HIV post-exposure treatment availability in relation to the elective upon which this risk assessment is based.
 Patient Signature Date

Nurse signature
 Date of Risk assessment