**DR J J WIJERATNE & PARTNERS**

**BELMONT HEALTH CENTRE**

**516 Kenton Lane, Harrow, Middlesex, HA3 7LT**

**Vaccinations should be arranged a minimum of 1 month in advance**

|  |  |  |  |
| --- | --- | --- | --- |
| *Personal Details* | | | |
| Name: | | Date of Birth: | |
| Date of Trip – To: From: | | | |
| Easiest Contact Number: Date form completed : | | | |
| ***Purpose of Visit*** | | | |
| Country: | Length of Stay | | Away from medical help at destination, how remote? |
| **1** |  | |  |
| **2** |  | |  |
| **3** |  | |  |
| **4** |  | |  |
| **5** |  | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Please tick below which best describes your trip* | | | | | | |
| 1. Type of trip | Business |  | Pleasure |  | Other |  |
| 1. Holiday Type | Package |  | Self-Organised |  | Backpacking |  |
|  | Camping |  | Cruise Ship |  | Trekking |  |
|  | Other |  |  |  |  |  |
| 1. Accommodation | Hotel |  | Relatives/Home |  | Other |  |
| 1. Travelling | Alone |  | With Family Friends |  | In a Group |  |
| 1. Area Type | Urban |  | Rural |  | Altitude |  |
| 1. Planned Activities | Safari |  | Adventure |  | Other |  |

|  |  |
| --- | --- |
| *Personal Medical History* |  |
| Are you well (Fit enough) to travel? |  |
| Known allergies e.g. eggs, antibiotics, nuts… |  |
| Are you pregnant? |  |
| Do you have a history of depression or psychiatric illness? |  |
| Have you ever had a serious reaction to a vaccination? |  |
| Do you or any close relative have epilepsy? |  |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Vaccination History (Add Date if known)* | | | | | |
| Have you ever had any of the following vaccination/Malaria tablets? | | | | | |
| Tetanus |  | Polio |  | Diptheria |  |
| Meningitis |  | Hepatitis A |  | Hepatitis B |  |
| Rabies |  | Yellow Fever |  | Influenza |  |
| Typhoid |  | Japanese Encephalitis |  | Tick Borne Encephalitis |  |
| Malaria |  | Other |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| FOR OFFICIAL USE BY PRACTICE NURSE  Recommended Vaccines | | | |
| Hepatitis A |  | Diptheria |  |
| Hepatitis B |  | Tetanus |  |
| Meningococcal ACWY |  | Polio |  |
| Yellow Fever |  | Rabies |  |
| Typhoid |  | Malaria Tablets |  |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SG/MAY 2017