**Travel Risk Assessment Form**

**Please complete this form and return it to the receptionist.**

**We would ask that you give us 5 working days notice to enable our Practice Nurse Team to complete your travel risk assessment and recommendations.**

**Please allow at least 4 weeks to make your requests, if you travel in less than 4 weeks we may not be able to offer you an appointment at the surgery and you may need to attend a private health clinic instead.**

|  |  |
| --- | --- |
| Name: |  |
| Date of birth: |  | Contact number: |  |
| Address: |  |

**Travel Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Departure Date: |  | Length of stay: |  |
| Return date: |  | Reason for travel: | Holiday / Work |
| Destinations: |
| Type of Accommodation:(e.g. Hotel, Self-Catering, Camping, Backpacking etc). |

**Medical History:**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Do you have, or have you had any serious illness, disability or mobility problem? |  |  |
| Are you receiving regular treatment or follow up with your GP/Hospital specialist? |  |  |
| Have you had any hospital admissions? |  |  |
| Have you ever had any surgery? |  |  |
| Do you have any allergies? |  |  |
| Have you had any travel related illness/injury which required assessment/treatment in hospital? |  |  |
| Do you have a condition which may be affected by travel? |  |  |
| Do you have any specific health concerns regarding your proposed trip? |  |  |
| Have you ever experienced any mental health issues, even mild anxiety or depression? |  |  |
| Are you pregnant, breastfeeding or planning pregnancy whilst travelling? |  |  |

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| **Further Details:***Please provide any other important information regarding your health, including problems experienced with previous travel:* |