SANDYLIGHT PHARMACY

Travel Clinic Risk Assessment Form (tRAF) Form

Date:

Patient's personal details

Title: Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Dr: ☐	Patient Address:
First Name:	NHS No. (if known):
Last Name:	GP Name and Address:
Telephone:	GP Telephone (if known):
Gender: Male: ☐ Female: ☐ D.O.B: _____	Would you like us to send a copy of this consultation to your GP? ☐

Dates, itinerary and purpose of trip

Date of departure:	Return date or overall length:

Country to be visited	Length of stay	Remote? Trek? Medical access? Altitude?
1.		
2.		
3.		
4.		

Mode of transport:

Personal Medical History

Tick which of the following applies to you	Yes	No	Details (reconfirmed at each appointment)
Are you feeling well today?			
Have you had any immunisations in the past 4 weeks?			
Do you have any recent or past medical history of note?			
Do you take any current or repeat medicines or are you taking halofantrine? Do you have any allergies to any medicines, latex or eggs?			
Have you had a serious reaction to a vaccine, antimalarial or doxycycline before?			
Do you known if you are hypersensitive to mefloquine or related compounds (e.g. quinine, quinidine) or excipients?			
Do you or any of your family suffer from epilepsy? Do you have a past history of black water fever? Do you have severe impairment of liver function?			
Do you suffer from any blood disorders such as thalassemia or sickle cell anaemia? Have you recently undergone radiotherapy, chemotherapy, steroids treatment?			
Do you have any history of the following: anxiety, depression, heart, lung, spleen, liver, kidney, immunity, blood conditions, disorders, diabetes, immunity, HIV-AIDs?			

Vaccination History

Have you had a vaccine, antimalarial or doxycycline before? (Please add dates)

Dip Tet Polio		Typhoid		Hepatitis A	
Hepatitis B		Meningitis		Yellow Fever	
Rabies		Jap B Encephalitis		Influenza	
Shingles		Meningitis B		Tick Borne Encephalitis	
MMR		Chickenpox		Malarial Tablets	

Other:

Women only

Tick which of the following applies to you	Yes	No	Details (reconfirmed at each appointment)
Are you pregnant or planning a pregnancy?			
Are you breastfeeding?			

Please add any further information which may be	

relevant e.g. Medicines, conditions…	

FOR OFFICIAL USE

Consultation Record		**For each consultation add:** date, batch No, expiry date, administration site and patient consent signature		
Vaccine	**Consultation 1**	**Consultation 2**	**Consultation 3**	**Price**
Dip / Tet / Polio				
Typhoid				
Hepatitis A				
Hepatitis B				
Meningitis				
Rabies				
Cholera				
Yellow Fever				
Other				
Other				

Malaria Oral Medicine	**Date**	**Quantity**	**Details**	**Price**
Atovaquone + Proguanil				
Lariam (mefloquine)				
Doxycycline				
Paludrine(chloroquine + proguanil)				
Chloroquine				

Total price.....

Additional travel advice:

Water and personal hygiene	☐	Travellers' diarrhoea	☐	Hepatitis B and HIV	☐
Insect bite prevention	☐	Animal bites	☐	Accidents	☐
Insurance	☐	Air travel	☐	Sun and heat protection	☐

Notes:

PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment.

Patient / Guardian signature..... /..... /..... Date.....

Pharmacist's signature...../..... /..... Date.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? **Yes / No**