**PARKLANDS SURGERY**

**FOREIGN TRAVEL ENQUIRY FORM**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB/EMIS No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESTINATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*PLEASE LIST ALL COUNTRIES***

LENGTH OF STAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF TRAVEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTACT TELEPHONE NO.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RECEPTIONIST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENQUIRY DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR ADMIN USE ONLY**

**ADMINISTRATION**

PREVIOUS VACCINES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VACCINES REQUIRED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPOINTMENT REQUIRED **YES** / **NO Malaria risk area**: **YES / NO / LOW**

APPOINTMENT DETAILS: DATE: \_\_\_\_\_\_\_\_\_ NURSE: \_\_\_\_\_\_\_\_\_\_\_ TIME: \_\_\_\_\_

**NOTES**

**Date Patient advised: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARKLANDS SURGERY**

**FOR ADMIN USE ONLY:**

|  |  |  |
| --- | --- | --- |
| **COUNTRIES VISITING** | **DATE OF TRAVEL** | **LENGTH OF STAY** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |

Please tick any of the following that apply:

Accommodation: HOTEL CAMPING CRUISE OTHER : ................................................. Travelling: ALONE WITH FRIENDS/FAMILY/GROUP

Location Type: URBAN RURAL ALTITUDE

Activity Type: SAFARI ADVENTURE OTHER:. ........................................... Purpose of trip: BUSINESS PLEASURE OTHER

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VACCINE** | **YES** | **NO** | **DECLINED** | **NOTES** |
| **Hep A 1 dose****Vaqta Paed****Epaxal****Avaxim****Booster dose** |  |  |  |  |
| **Typhoid vaccine pre-filled syringe****Typhim** |  |  |  |  |
| **Hep A & Typhoid combined vaccine pre-filled syringe****Viatim** |  |  |  |  |
| **Hep B Vaccine pre-filled syringe****Engerix B/****Hb vax pro****Course of three****Booster dose** |  |  |  |  |
| **Tetanus, Diptheria, Polio pre-filled syringe****Primary dose****Booster dose** |  |  |  |  |
| **Disease prevention advised?** | **YES** | **Comments** |
| **Jap E** |  |  |
| **TBE** |  |  |
| **MEN ACWY** |  |  |
| **Cholera** |  |  |
| **Yellow Fever** |  |  |
| **MMR** |  |  |
| **Other** |  |  |
| **Malaria** |  | **Malarone Doxy Mefloquine****Proguanil Over the Counter****Days in risk area: ....................** |

**If any of the following has been advised please write W for written or D for discussed in the box:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Food & Water** |  | **Blood borne virus risk** |  | **Mosquito bite/malaria prevention** |  | **Altitude** |  |
| **Traveller’s diarrhoea** |  | **Rabies advice** |  | **Medical preparation** |  | **Insurance** |  |