Travel Consultation

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| **Patient details *(Label, Nurse to complete)*: DATE:** | |
| **Email address:** | |
| **Contact phone number: (Home) (Work) (Mobile)** | |
| **Occupation:** | **Company Name:** |
| **General Practitioner (Name and address):** | |
| **Next of Kin: (Name) (Contact Ph. Number)** | |
| **YOUR HEALTH** | |
| **VACCINATIONS/IMMUNISATIONS**  **List any VACCINATIONS had within the last 10 years:** | |
| **Have you had routine childhood immunisations? YES □ NO □** | |
| **Please describe any reactions to vaccinations:** | |
| **Please list ANY allergies you have including FOOD, EGGS, MEDICINES: (Some vaccines contain eggs)** | |
| **What PRESENT or PAST medical conditions do you have?** | |
| **Please list any Medications you are currently taking (including those that affect the immune system) or that you have had within the last 3 months:** | |
| **Do you currently have a temperature, or cold/”flu” symptom? YES □ NO □** | |
| ***FEMALES ONLY*: Are you pregnant/contemplating pregnancy? YES □ NO □** | |
| **Do you have a history of any of the following? (Please tick)**  **Psoriasis YES □ NO □ Convulsion/Seizure/Epilepsy YES □ NO □**  **Hepatitis YES □ NO □ Heart Rhythm Problems YES □ NO □**  **Depression YES □ NO □ Psychiatric unwellness YES □ NO □**  **Cancer YES □ NO □ Blood immune disorders YES □ NO □**  **Blood Clotting YES □ NO □ Recent Surgery YES □ NO □** | |
| **COUNTRIES TRAVELLING TO:** | **DURATION:** |
|  |  |
| **Departure date: Return date: Duration of travel:** | |
| **YOUR TRIP** | |
| 1. **Travel purpose:**   **Business □ Holiday □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   1. **Type of travel:**   **Rural □ Urban □ Guided tour □ Back packing □**  **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   1. **Accommodations:**   **(Eg Hotel, Home stay etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

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| **What, if any, specific issues do you wish to have covered in your appointment?** |
| **If you are having the Yellow Fever vaccine, have you read & understood the Yellow Fever Information Handout?**  **YES □ NO □** |
| **Informed consent:** I acknowledge that the information given above is truthful. I accept all information given will be kept confidential, and will not be released without my authority. I consent to my healthcare provider being informed of vaccinations received in order to update applicable records. I realise that I may be given vaccinations and understand what they are for, and side effects that may be expected from them. I consent to having these vaccinations and to the reporting of any adverse events which may occur to the Centre for Adverse Reactions Monitoring (CARM). I understand that the above information may be used for research use. In the event of non-payment of monies owing by me, The Doctors Phoenix reserves the right to pass on to me all charges related to debt collection.  **Please circle, then sign. Self / Parent / Caregiver/Gaurdian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |