Travel Consultation

We hear you are making travel plans and require a travel consult.
Please complete the attached Travel Consult Form and email back to reception. When completing the form add as much detail as you can, all the destinations, including stopovers in order of your trip and note any activities, like diving, trekking, safari etc.

Once your form is returned, we will contact you to make an appointment with our Travel Team. In this consult you will discuss potential travel risks, safe travel, required medications and recommended vaccinations. **Please be aware that The Ministry of Health do not cover travel consultations and immunisations**. Initial Travel consults will incur a fee and any recommended vaccinations will incur an additional charge, follow up vaccination appointments will also incur a fee plus the cost of any vaccinations.

Name:	**Date:**
Date of Birth:	**Ethnicity:**
Address:	
Email address:	
Contact phone number: (Home)	**(Work)** **(Mobile)**
Occupation:	**Company Name:**
General Practitioner (Name and address):	
Next of Kin: (Name)	**Relationship:** **(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 <u>ANY</u> allergies you have including <u>FOOD, EGGS, MEDICINES</u>: (Some vaccines contain eggs)	
What <u>PRESENT</u> or <u>PAST</u> 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:**
   _____
2. **Type of travel:**
   Rural □ **Urban** □ **Guided tour** □ **Back packing** □
   Other: _____
3. **Accommodations:**
   (Eg Hotel, Home stay etc.)
   _____

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/Guardian

Signature_____