

Travel Clinic Risk Assessment Form (tRAF) Form				Date:				
Patient's personal details								
Title: Mr: Miss: M	s: Dr: Dr:	Patient Address:						
First Name:		AUG No. (if Imparts)						
Last Name:		NHS No. (if known):  GP Name and Address:						
	C. Harris and Address.							
Telephone: GP 1			GP Telephone (if known):					
Gender: Male: Female:		Would you like us to cond a copy of this consultation to your CD?						
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 ove	erall le	ength:					
Country to be visited	Remote? Trek?	Medi	cal ac	cess? Altitude?				
1.	Length of stay							
2.								
3.								
4.								
-T-		Mode of transpor	t:					
Daysand Madical History		·						
Personal Medical History			V		But the former former distance have a state of			
Tick which of the following applies to you			Yes	No	Details (reconfirmed at each appointme			
Are you feeling well today?								
Have you had any immunisations in the p								
Do you have any recent or past medical hist	• •							
Do you take any current or repeat medicines, latex	nes or are you taking halofant : or eggs?	trine? Do you						
Have you had a serious reaction to a vacci		ne before?						
Do you known if you are hypersensitive to r quinidine) or excipients?	nefloquine or related compour	nds (e.g. quinine,						
Do you or any of your family suffer from e fever? Do you have severe impairment of	epilepsy? Do you have a past have the past have function?	nistory of black water						
Do you suffer from any blood disorders sur Have you recently undergone radiotherap								
Do you have any history of the following:	anxiety, depression, heart, lu	ıng, spleen,						
liver, kidney, immunity, blood conditions,	disorders, diabetes, immuni	ty, HIV-AIDs?						
Vaccination History								
Have you had a vaccine, antimalarial or d	oxycycline before? (Please ac	dd dates)						
Dip Tet Polio	Typhoid			Нера	atitis A			
Hepatitis B	Meningitis			Yello	ow Fever			
Rabies	Jap B Encephalitis			Influenza				
Shingles	Meningitis B			Tick	Borne Encephalitis			
MMR	Chickenpox			Mala	rial Tablets			
Other:								
Women only								
Tick which of the following applies to you			Yes	No	Details (reconfirmed at each appointme			
Are you pregnant or planning a pregnancy	?							
Are you breastfeeding?								
Please add any further			1	1	I			
information which may be								



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## FOR OFFICIAL USE

/accine C ip / Tet / Polio ryphoid lepatitis A	onsultation		da	te, batch No, expiry date,	administratio	ii site and patient co	onsent signature	
yphoid		1	C	onsultation 2	Co	onsultation 3		Price
enatitis A								
enatitis A								
epatitis A								
lepatitis B								
Neningitis								
abies								
holera								
ellow Fever								
ther								
ther								
lalaria Oral Me	dicine D	ate		Quantity	Det	ails	Price	
tovaquone + Proguan	ıil							
ariam (mefloquine)								
aludrine(chloroquine	+ proguanil)							
hloroquine	P S							
					•	Total p	orice	
ditional travel ac		1	T =			T		
' '						Hepatitis B and HIV Accidents		
Insurance			Air travel		Sun and heat	protection		
Notes:			All clave			Sun and near	protection	