Barnet Travel Clinic East Barnet Herts EN4 8TD

Date: ____/____/ 2014

Patient's personal details	
Title: Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Dr: ☐	Patient Address:
Name:	
Surname:	GP Name and Address:
Email:	
Mobile:	Would you like your GP to be notified of this consultation? ☐
Gender: M: ☐ F: ☐ D.O.B: _ _ / _ _ / _ _	If this is a baby or child under 12yrs please state the weight _____

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.		
5.		

Personal Medical History

please ask if you require assistance in completing this form

Tick which of the following applies to you	Yes	No	Details (reconfirmed @ each appointment)
Are you feeling well today ?	☐	☐	
Have you had any immunizations 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 any form of depression or epilepsy?	☐	☐	
Do you have a past history of black water fever or any issue with your thymus gland?	☐	☐	
Do you have severe impairment of liver function?	☐	☐	
Do you suffer from any blood disorders such as thalassaemia or sickle cell anaemia?	☐	☐	
Have you recently undergone radio therapy, 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)

Tetanus	Polio	Diphtheria
Typhoid	Hepatitis A	Hepatitis B
Meningitis	Yellow Fever	Influenza
Rabies	Jap B Enceph	Tick Borne

Other Malaria Tablets

Women only

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

Please write below 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				
Combined Hep A + Typhoid				
Combined Hep A + Hep B				
Hep A				
Hep B				
Meningitis				
Rabies				
Cholera				
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

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**

for any further information please visit our website *www.barnettravelclinic.com*