

Travel Clinic Risk Asse	ssm	ent Form (tRAF	F) Form			Date:	
Patient's personal details							
Title: Mr: Miss: M	s: 🗌	Mrs: Dr: Dr	Patient Address:				
First Name:			August (g)				
Last Name:			NHS No. (if know GP Name and Ad-				
Telephone:							
			GP Telephone (if	know	n):		
Gender: Male: Female:			Would you like u	s to se	end a o	copy of this consultation to your GP?	٦
D.O.B:							
Dates, itinerary and purpose of	trin						
Date of departure:	пр		Return date or ove	rall le	ngth:		
Country to be visited	Le	ength of stay	Remote? Trek?				
1.							
2.	_						
3.							
4.							
			Mode of transpor	t:			
Daysanal Madical History							
Personal Medical History					١		
Tick which of the following applies to you				Yes	No	Details (reconfirmed at each appointm	ent)
Are you feeling well today?							
Have you had any immunisations in the p							
Do you have any recent or past medical his Do you take any current or repeat medicin			rino? Do vou				
have any allergies to any medicines, latex	or eg	gs?	Tille: Do you				
Have you had a serious reaction to a vacc	ine, aı	ntimalarial or doxycyclir	ne before?				
Do you known if you are hypersensitive to r quinidine) or excipients?	nefloq	uine or related compoun	ds (e.g. quinine,				
Do you or any of your family suffer from of fever? Do you have severe impairment of	liver f	unction?					
Do you suffer from any blood disorders su Have you recently undergone radiotherap							
Do you have any history of the following: liver, kidney, immunity, blood conditions,							
Wasterday III day							
Vaccination History Have you had a vaccine, antimalarial or d	010101	cline before? (Dlesse ad	d datas)				
Dip Tet Polio	oxycy	`	u dates)		المما	atitis A	
Hepatitis B		Typhoid Meningitis				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 appointm	ent)
Are you pregnant or planning a pregnancy	/?				-,-	and the first of t	
Are you breastfeeding?							
Please add any further					<u> </u>	1	
information which may be							



	relevant e.g. Medicines, conditions				
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FOR OFFICIAL USE

p / Tet / Polio photid epatitis A epatitis B eningitis eningit	Dip / Tet / Polio Typhoid Hepatitis A Hepatitis B Meningitis Rabies Cholera Cholera Other Other Other Other Malaria Oral Medicine Date Quantity Details Price Atoxaquone + Proguanit Lariam (mefloquine) Doxycycline Doxycycline Doxycycline Paludrine(chloroquine + proguanit) Chioroquine Iditional travel advice: Water and personal hygiene Travellers' diarrhoea Hepatitis B and HIV Insect bite prevention Animal bites Accidents	Consultation Record		For each consultation ac date, batch No, expiry dat		n site and patient co	onsent signature	
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