

Travel

Fylde Road Pharmacy

Date: __ / __ / 20 __

Patient's personal details	
Title: Mr: <input type="checkbox"/> Miss: <input type="checkbox"/> Ms: <input type="checkbox"/> Mrs: <input type="checkbox"/> Dr: <input type="checkbox"/>	Customer Address:
Name:	GP Name and Address:
Surname:	
Email:	Would you like your GP to be notified of this consultation? <input type="checkbox"/>
Mobile:	
Gender: M: <input type="checkbox"/> F: <input type="checkbox"/> D.O.B: __ / __ / __	

Dates of Trip

Date of departure

Return date or overall length

Itinerary and purpose of visit

Country to be visited	Length of stay	Remote? Trek? Medical access? Altitude?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Personal Medical History

Tick which of the following applies to you	Yes	No	Details (reconfirmed @ each appointment)
Are you feeling well today?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any immunizations in the past 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any recent or past medical history of note?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any current or repeat medicines?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any allergies to any medicines?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a serious reaction to a vaccine, antimalarial or doxycycline before?	<input type="checkbox"/>	<input type="checkbox"/>	
Does having an injection make you feel faint?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you or any of your family suffer from epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you recently undergone radio therapy, chemotherapy, steroids treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any history of the following: anxiety, depression, heart, lung, spleen, liver, kidney, immunity, blood conditions, disorders, diabetes, immunity, HIV-AIDs?	<input type="checkbox"/>	<input type="checkbox"/>	

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?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	

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					
<input type="checkbox"/>	Water and personal hygiene	<input type="checkbox"/>	Travellers' diarrhoea	<input type="checkbox"/>	Hepatitis B and HIV
<input type="checkbox"/>	Insect bite prevention	<input type="checkbox"/>	Animal bites	<input type="checkbox"/>	Accidents
<input type="checkbox"/>	Insurance	<input type="checkbox"/>	Air travel	<input type="checkbox"/>	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.....

Pharmacists signature...../...../..... Date.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? **Yes / No**