THREE SHIRES MEDICAL PRACTICE TRAVEL RISK ASSESSMENT FORM

Name:	**Date of birth:**	
	Male ☐	**Female** ☐
Email:	**Landline Number:**	
	Mobile Number:	

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW

Date of departure:		**Total length of trip:**	
Country to be visited	**Exact location or region**	**City or Rural**	**Length of stay**
1			
2			
3			

TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY

Holiday	☐	Staying in hotel	☐	Backpacking	☐
Business trip	☐	Cruise ship trip	☐	Camping/hostels	☐
Expatriate	☐	Safari	☐	Adventure	☐
Volunteer work	☐	Pilgrimage	☐	Diving	☐
Healthcare worker	☐	Medical tourism	☐	Visiting family/friends	☐

PLEASE SUPPLY THE FOLLOWING MEDICAL HISTORY (Y/N)

Are you pregnant ☐	**Do you have any allergies** ☐
SIGNED:	**PRINT NAME:**
DATE:	

Additional information:

TREATMENT PLAN FOLLOWING ASSESSMENT

Assessment carried out by:

VACCINATIONS TO BE GIVEN	DATE GIVEN
1	
2	
3	
4	

Any additional comments / information