PGD Patient Consultation Form Travel Health

This form is designed to be used as a guide during a face to face consultation.

Client Demographic Details

Name		**Sex**	
DOB		**Age**	
Phone		**Email**	
Address			
GP Surgery		**Consent to share information with GP if required**	Yes/No

Clinician has checked correct details*	Yes/No
Consent to storage of health information	Yes/No

**Good practice to check that contact details are correct and current. For travel where certificates are issued, name must match passport.*

Consent for Consultation and Treatment

Client is able to consent			Yes/No
Client is accompanied by someone able to consent on their behalf* *(Mother, father or other adult with parental responsibility, legal guardian or person with lasting power of attorney)			Yes/No/NA
Details of person consenting on behalf of another			
Name		Relationship / legal status	
Address			
The client is happy to go ahead with the consultation and treatment. The clinician will explain the recommended treatment, including relevant benefits, potential side effects, and appropriate measures for managing any adverse reactions.			Yes/No

Travel Details

Date of Departure		Length of Trip	
Countries/regions to be visited			
Geography (urban, rural, jungle, safari, coastal, desert high altitude)			
Purpose (adventure, aid work, business, volunteer, cruise, diving, health worker, holiday, long term, medical treatment, pilgrimage, visiting friends and family, gap year.			
Type/s of accommodation (hotel, hostel, campsite)			
Reason for today's appointment			

Vaccine History

Name of vaccine	Date of last dose	Course complete	Notes
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
Childhood vaccinations up to date?			Yes/No

Medical History

Is client fit and well today?	Yes/No
Does the client have any allergies, particularly to eggs or chicken protein?	Yes/No
Has the client ever had a reaction to any vaccination or a history of fainting?	Yes/No
Is the client pregnant or breastfeeding?	Yes/No
Does the client have any of the following	
• blood or clotting disorders	Yes/No
• kidney or liver problems	Yes/No
• heart or lung problems	Yes/No
• diabetes	Yes/No
• epilepsy or neurological condition	Yes/No
• mental health condition (depression anxiety other)	Yes/No
• disability or mobility problems	Yes/No
• Other condition requiring regular treatment from GP or specialist	Yes/No
Details if yes to any of the above or if client is currently unwell	
Current Medications – Include over-the-counter remedies and contraception	

Additional questions for clients receiving yellow fever vaccine. Note that you must be a registered centre in order to administer this vaccine. See websites for NaTHNaC/TRAVAX/Public Health Scotland.

Has the client had a reaction to a previous yellow fever vaccine?	Yes/No
Does the client have any illness that might affect their immune system for example leukaemias, lymphoma, cellular immune deficiencies, chronic lymphoproliferative conditions, or have ever received a stem cell transplant?	Yes/No
Does the client have cancer or have they had cancer in the past?	Yes/No
Is the client taking any medicines now or within the last 12 months that affects their immune system; for example steroids, biological or non-biological immune modulating medicines treatment following an organ transplant	Yes/No
Is the client having chemotherapy, or have they had chemotherapy within the last year?	Yes/No
Has the client ever been told they may have a problem with their thymus gland includes myasthenia gravis or a thymoma?	Yes/No
Does the client have a first-degree family relative i.e. mother, father, full sister, brother or child who has had a serious adverse reaction to yellow fever vaccine?	Yes/No
Is the client living with HIV?	Yes/No
Has the client had an operation to remove their thymus gland for any reason including during cardiac surgery?	Yes/No
Details if yes to any of the above	

Recommended Vaccinations and Treatment (see NaTHNaC /TRAVAX websites)

Vaccine	**Country/Region**	**Has client had vaccine before?**	**Is client suitable for vaccination?**	**Cost**
		Yes/No	Yes/No	
		Yes/No	Yes/No	
		Yes/No	Yes/No	
		Yes/No	Yes/No	
		Yes/No	Yes/No	
		Yes/No	Yes/No	
		Yes/No	Yes/No	
Antimalarials				

Travel advice given by clinician

Accidents and personal safety	Yes/No	Food/water and diarrhoea	Yes/No
Blood transmitted infection	Yes/No	Bite prevention	Yes/No
Sun Cream	Yes/No	Travel insurance	Yes/No
Clinician has discussed Female Genital Mutilation (FGM) where relevant			Yes/No/NA

Details of treatment administered/supplied

Vaccine	Batch Number	Expiry Date	Route	Site	Administered by

Details of other treatment supplied including anti-malarials

Additional Clinical Notes

Details of Registered Healthcare Professional Completing the Consultation

Name	Qualification	Signature	Date