Travel Clinic Risk Assessment Form (tRAF)
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Date: _ _ / _ _ / 2 0 _ _

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: _ _ / _ _ / _ _	

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.		Mode of transport:

Personal medical history

Tick which of the following applies to you	Yes	No	Details (reconfirmed at each appointment)
Are you feeling well today?	☐	☐	
Have you had any immunisations 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 epilepsy?	☐	☐	
Do you have a past history of black water fever?	☐	☐	
Do you have severe impairment of liver function?	☐	☐	
Do you suffer from any blood disorders such as thalassemia or sickle cell anaemia?	☐	☐	
Have you recently undergone radiotherapy, 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)

Dip Tet Polio	Typhoid	Hepatitis A
Hepatitis B	Meningitis	Yellow Fever
Rabies	Jap B Encephalitis	Influenza
Shingles	Meningitis B	Tick Borne Encephalitis
MMR	Chickenpox	

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...