Shelvers Pharmacy Holiday Travel Clinic

Patient's personal details- BLOCK LETTERS ONLY PLEASE

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? Yes / No
Gender: M: F: D.O.B: _ _ / _ _ / _ _	Todays Date / / 20

Dates, itinerary and purpose of trip

Date of departure:.....

Return date or overall length:.....

More Details about the trip. Is It-

Country to be visited	Length of stay	Remote/Rural	- Back Packing	- Sports activity-	Altitude above 2500m-	Hotel Only
1.		Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
2.		Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
3.		Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
4.		Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Mode of transport with in country:

Personal 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- Please include date of vaccination and brand.

Have you had a vaccine, antimalarial or doxycycline before? (Please add dates when you had vaccination and the Brand)

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.....

Tablets.....

For Women only

Tick which of the following applies to you

Are you pregnant or planning a pregnancy? YES /NO

Are you breastfeeding? YES /NO

(to be reconfirmed each appointment)

OFFICE USE

TP / PD £ / / 2024

Email & Text sent / / 2024

2nd TEXT sent / / 2024

Visit our website www.HolidayTravelClinic.co.uk

for full vaccination details and price list.

Once we have this medical form back and it has been assessed by the pharmacist, we can arrange an appointment as quick as the same day.

PTO

Consultation Record

For each consultation add:
date, batch No, expiry date, administration site and patient consent signature

Vaccine	Consultation 1	Consultation 2	Consultation 3
Dip / Tet / Polio			
Typhoid			
Hepatitis A			
Hepatitis B			
Meningitis			
Rabies			
Cholera			
Yellow Fever			
Other			
Other			

Malaria Oral Medicine	Date	Quantity	Details	Price
Atovaquone + Proguanil				
Lariam (mefloquine)				
Doxycycline				
Paludrine(chloroquine+ proguanil)				
Chloroquine				

Total price……..

Additional travel advice:

Water and personal hygiene	☐	Travellers' diarrhoea	☐	Hepatitis B and HIV	☐
Insect bite prevention	☐	Animal bites	☐	Accidents	☐
Insurance	☐	Air travel	☐	Sun and heat protection	☐

Notes:

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.....

Pharmacist's signature...../..... /..... Date.....

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