**CHURCH STREET PRACTICE**

**PRE-TRAVEL INFORMATION/QUESTIONNAIRE**

**INTRODUCTION**

The completion of this form is to provide the practice nurse with details of your forthcoming trip in order for them to give you the correct travel advice/vaccinations in advance of your journey with the aim of helping you keep yourself healthy.

Please read the remainder of the information below and return the whole document to us at least 4 to 6 weeks before you are scheduled to travel for short stays abroad and 3 months before long trips. If you would prefer you can e-mail this form to [churchstreet.reception@nhs.net](mailto:churchstreet.reception@nhs.net).

**TELEPHONE CONSULTATION**

On receipt of the completed form a convenient telephone consultation with one of our practice nurses will be arranged for you by Reception so that advice can be provided and discussion can take place with regard to which vaccinations may be required (to include Malaria tablet advice as appropriate)

As this telephone discussion is a formal consultation you need to:

* Be in an appropriate place to take the phone call
* Have any **travel record cards** that you have to hand; or
* If you have registered with us in the last six months could you please obtain a **full vaccination history** from your previous GP surgery as it is unlikely that your notes will have been transferred.

We would suggest that you look at [**www.fitfortravel.nhs.uk**](http://www.fitfortravel.nhs.uk)to read more about the health risks in the country you are visiting. This site will tell you the up to date recommended vaccinations and malaria advice for your destination.

**CHARGES**

Please find below a price list of chargeable vaccinations. The majority of these have to be given at least four to six weeks before travel and are ordered on a named patient basis. There is no charge for diphtheria, tetanus, polio, hepatitis A or typhoid vaccinations. These vaccinations should ideally be given at least two weeks before departure.

**Charges** (Prices are a guideline and can be subject to change)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | Requirements (please tick) | | **Total cost**  **(cash/**  **cheque)** | **Total cost (debit/**  **credit card)** |
| Hepatitis B | Course of 3 |  | £120.00 | £122.50 |
| Single booster dose |  | £ 40.00 | £ 40.80 |
| Rabies | Course of 3 |  | £192.00 | £195.75 |
| Japanese Encephalitis | Course of 2 |  | £215.00 | £219.20 |
| Ticborne Encephalitis | Course of 2 |  | £126.00 | £128.50 |
| Course of 3 |  | £189.00 | £192.70 |
| Meningococcal (Menveo) | Single dose |  | £ 55.00 | £ 56.10 |
| Cholera (oral | Private Prescription |  | £ 17.50 | £ 17.85 |
| Malaria |  |

*Our fees include the cost of the drug including carriage and VAT, a private prescription, practice nurse time and a small administration charge. Debit/Credit card charges also include the transaction cost payable by the Practice*

**Appendix 1**

Appointment Booked by : Date/Time: With:

**PRE-TRAVEL QUESTIONNAIRE**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal details** | | | | | | | | | | |
| Name: | | | | | | | Date of birth:  Male [ ] Female [ ] | | | |
| Preferred Contact Telephone No: | | | | | | | | | | |
| **Details of planned travel** | | | | | | | | | | |
| Countries and cities to be visited (or please attach itinerary) | | Length of stay | | | | Away from medical help at destination, if so, how remote? | | | | |
|  | |  | | | |  | | | | |
| Date of Departure from UK: | | | | | Date of Return to UK: | | | | | |
| **Please tick as appropriate below to best describe your trip** | | | | | | | | | | |
| **1. Type of trip** | Business | |  | Pleasure | | | |  | Other |  |
| **2. Holiday type** | Package | |  | Self organised | | | |  | Backpacking |  |
| Camping | |  | Cruise ship | | | |  | Trekking |  |
| **3. Accommodation** | Hotel | |  | Relatives / family home | | | |  | Other |  |
| **4. Travelling** | Alone | |  | With family / friend | | | |  | In a group |  |
| **5. Staying in area which is** | Urban | |  | Rural | | | |  | Altitude |  |
| **6. Planned activities** | Safari | |  | Adventure | | | |  | Other |  |
| **Personal medical history** | | | | | | | | | | |
| Do you have any allergies for example to eggs, antibiotics, or nuts? | | | | | | | | | | |
| Have you ever had a serious reaction to a vaccine given to you before? | | | | | | | | | | |
| Does having an injection make you feel faint? | | | | | | | | | | |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | | | | | | | | | | |
| *Women only:* Are you pregnant or planning pregnancy or breast feeding? | | | | | | | | | | |
| **I CONFIRM THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE**  Signed: Date: | | | | | | | | | | |

**CONSENT**

If you wish the Practice Nurse to discuss your vaccinations or malaria requirements with a family member on your behalf please complete the section below:

|  |  |
| --- | --- |
| Name of whom we can speak to |  |
| Contact Telephone Number |  |
| Signed Date | |

If you do not complete this section then your requirements will not be discussed with anyone else.