

Travel

Bush Pharmacy

Date: \_\_/\_\_/20\_\_

Patient's personal details	
Title: Mr: <input type="checkbox"/> Miss: <input type="checkbox"/> Ms: <input type="checkbox"/> Mrs: <input type="checkbox"/> Dr: <input type="checkbox"/>	Customer Address:
Name:	GP Name and Address:
Surname:	
Email:	
Mobile:	Would you like your GP to be notified of this consultation? <input type="checkbox"/>
Gender: Male: <input type="checkbox"/> Female: <input type="checkbox"/> D.O.B: __/__/__	

**Dates of Trip**

Date of departure

Return date or overall length

**Itinerary and purpose of visit**

Country to be visited	Length of stay	Remote? Trek? Medical access? Altitude?
1.		
2.		
3.		
4.		
5.		

**Personal Medical History**

Tick which of the following applies to you	Yes	No	Details (reconfirmed @ each appointment)
Are you feeling well today?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any immunizations in the past 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any recent or past medical history of note?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any current or repeat medicines?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any allergies to any medicines?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a serious reaction to a vaccine, antimalarial or doxycycline before?	<input type="checkbox"/>	<input type="checkbox"/>	
Does having an injection make you feel faint?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you or any of your family suffer from epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you recently undergone radio therapy, chemotherapy, steroids treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any history of the following: anxiety, depression, heart, lung, spleen, liver, kidney, immunity, blood conditions, disorders, diabetes, immunity, HIV-AIDs?	<input type="checkbox"/>	<input type="checkbox"/>	

**Vaccination History**

Have you had a vaccine, antimalarial or doxycycline before? (Please add dates)		
Tetanus	Polio	Diphtheria
Typhoid	Hepatitis A	Hepatitis B
Meningitis	Yellow Fever	Influenza
Rabies	Jap B Enceph	Tick Borne
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?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	

**Please write below any further information which may be relevant e.g. medicines, conditions...**

**FOR OFFICIAL USE**

<b>Consultation Record</b>		<b>For each consultation add: date, batch No, expiry date, administration site and patient consent signature</b>		
<b>Vaccine</b>	<b>Consultation 1</b>	<b>Consultation 2</b>	<b>Consultation 3</b>	<b>Price</b>
Dip / Tet / Polio				
Typhoid				
Combined Hep A + Typhoid				
Combined Hep A + Hep B				
Hep A				
Hep B				
Meningitis				
Rabies				
Cholera				
Other .....				

  

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

**Total Price.....**

<b>Additional travel advice</b>					
<input type="checkbox"/>	Water and personal hygiene	<input type="checkbox"/>	Travellers' diarrhoea	<input type="checkbox"/>	Hepatitis B and HIV
<input type="checkbox"/>	Insect bite prevention	<input type="checkbox"/>	Animal bites	<input type="checkbox"/>	Accidents
<input type="checkbox"/>	Insurance	<input type="checkbox"/>	Air travel	<input type="checkbox"/>	Sun and heat protection

**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 signature...../...../.....

Date.....

Pharmacists signature...../...../.....

Date.....

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