Island Travel Clinic

Travel Risk Assessment Form

Please complete clearly all sections of this assessment form prior to your travel clinic appointment.

SECONDARY

1. Patient Information					☐
Title:	**Miss / Mr / Mrs / Ms / Mstr / Mx /**	Gender Identity:	☐ Female ☐ Male ☐ Trans ☐ Other		
Family Name:		Marital Status:	☐ Single ☐ Married ☐ Civil Partnership ☐ Separated ☐ Divorced ☐ Other		
Given Name(s):		Ethnicity: Select A and B	A: ☐ White ☐ Black ☐ Asian ☐ Mixed ☐ Other B: ☐ British ☐ European ☐ Other		
Known As:		First Language: If not English			
Previous Family Name:		Resident Since: Month/Year	/		
Date of Birth:		Reason For Registering with the Practice:	☐ Visitor / On Business / Non-Resident Contractor ☐ Secondary / Specialist Service ☐ Second Opinion		
Jersey SSD No/Card:	Seen By:				
Jersey SSD HIF Status: (For Practice to complete)	☐ HIO ☐ HMA ☐ Private	Identification Confirmed: (Passport / Driving Licence)	☐ Yes ☐ No	ID Type:	Seen By:

2. Home Address and Contact Information (For ID purposes Utility Bill/Bank Statement or Tax/SSD Notification dated within 3 months is valid)					☐
Current Home Address:		Home Telephone:			
		Work Telephone:			
		Mobile Telephone:			
		Personal Email Address:			
Post-Code:		Address Confirmed: Dated within 3 months of issue	☐ Yes ☐ No	Doc. Type:	Seen By:

4. Emergency Contact/Parent/Guardian/Next of Kin Information				☐
Title:	**Miss / Mr / Mrs / Ms / Mx /**	Home Address & Post-Code: ☐ Same as Section 2		
Family Name:				
Given Name(s):				
Date of Birth:		Mobile Telephone:		
Relationship to Patient:		Your Next of Kin:	☐ Yes ☐ No	
Consent for us to Discuss Your Record:	☐ Yes ☐ No	Your Official Carer:	☐ Yes ☐ No	

4. Existing GP Information (not required for Island Medical Centre patients)			
GP Name:		Telephone Number:	
GP Address:			

5. ID Confirmation (not required for Island Medical Centre patients)	
Please provide the following documents/information (including parent/guardian in case of a child): ☐ Photographic ID (e.g. Passport/Driving Licence)	For Practice Use Only Seen By: Date:

6. Dates of Trip			
Departure Date:		Return Date:	

7. Itinerary and purpose of visit (including any stopovers)		
Country to be visited	Length of stay	Away from medical help at destination? If so, how remote?

8. Please select the description(s) that best describes your trip	
Type of Trip:	☐ Business ☐ Pleasure ☐ Medical/Dental ☐ Other
Holiday Type:	☐ Package ☐ Self-Organised ☐ Backpacking ☐ Camping ☐ Cruise Ship ☐ Trekking ☐ Other
Accommodation:	☐ Hotel ☐ Relatives/Family Home ☐ Other
Travelling:	☐ Alone ☐ With Family/Friend ☐ In A Group
Staying in area:	☐ Urban ☐ Rural ☐ Altitude
Planned Activities:	☐ Safari ☐ Adventure ☐ Other

9. Personal Medical History
Do you have any recent or past medical history of note? (this includes diabetes, heart or lung conditions, thymus disorder): ☐ Yes ☐ No If Yes please provide details:
Do you currently take any medication?: ☐ Yes ☐ No If Yes please provide details of any current or repeat medication:
Do you have any allergies for example to eggs, antibiotics, nuts? ☐ Yes ☐ No If Yes please provide details:
Have you ever had a serious reaction to a vaccine given to you before? ☐ Yes ☐ No If Yes please provide details:
Does having an injection make you feel faint? ☐ Yes ☐ No If Yes please provide details:
Do you or any close family member have epilepsy? ☐ Yes ☐ No If Yes please provide details:
Do you have any history of mental illness including depression or anxiety? ☐ Yes ☐ No If Yes please provide details:
Have you recently undergone radiotherapy, chemotherapy or steroid treatment? ☐ Yes ☐ No If Yes please provide details:
Women only: Are you pregnant or planning pregnancy or breast feeding? ☐ Yes ☐ No
Have you taken out adequate travel insurance? If you have a medical condition, have you informed the insurance company about this? ☐ Yes ☐ No
Please give further information that may be relevant, including any future travel plans within six months of your return from this trip.

10. Vaccination History

Have you ever had any of the following vaccinations/malaria tablets, and if so when?

☐ Hepatitis A	☐ Hepatitis B	☐ Diphtheria
☐ Typhoid	☐ Tetanus	☐ Polio
☐ Meningitis	☐ Yellow Fever	☐ Influenza
☐ Rabies	☐ Japanese B Encephalitis	☐ Tick-borne Encephalitis
☐ MMR / Childhood Vaccines	☐ Other	☐ Malaria Tablets

8. Patient Declaration, Confidentiality Agreement, Personal Data Statement and Communication ☐

In the case of a child under the age of 16, This declaration should be signed 'for and on behalf of' the child named on this registration form by the Parent/Legal Guardian as given in section 4.

Your Personal Information (Data Protection and Patient Privacy):
The information collected on this application form will be used by Island Medical Centre (hereafter the 'Practice') for the purposes of healthcare related services and practice administration. Personal information we hold about you is processed for the purposes of 'Employment and Social Fields' (Article 8) 'Medical Purposes' (Article 15) and 'Public Health' (Article 16) of the Data Protection (Jersey) Law 2018. This may require your personal data including, relevant details of your medical history, to be shared with other approved healthcare providers for the purpose of referrals and for other lawful purposes related to the Practice procedures. Further information on how we hold and process your data can be found in our Data Protection and Patient Privacy Policy.

General Practice Central Services (GPCS):
All Jersey GP Practices and other approved healthcare service providers, such as the out-of-hours doctors, use a central medical records system known as EMIS. This allows access to a 'shared medical record' to ensure that the provider or clinician has immediate up-to-date and accurate information about your health and any current treatment you may be having. You do however have the right to 'opt out' of sharing some or all of your medical records. Please ask us for more information and where appropriate an Opt-in/Out Form for completion. All approved healthcare service providers with authorised access to GPCS have signed strict confidentiality agreements which are bound by the Data Protection (Jersey) Law 2018.

Your Declaration to us:

- I confirm that all the information I have given in this registration form is accurate to the best of my knowledge.
- I understand that the Practice has the right to accept or decline my registration application at any time.
- I understand that by attending a consultation with a GP or other healthcare professional of the Practice, I accept the Practice terms of service and fee schedule issued and displayed in the Practice premises and as amended from time to time.
- I hereby agree to pay any incurred service fees from the Practice at the time of attendance or treatment.
- I expressly consent that on registration or prior to accepting any credit arrangement from the Practice, where appropriate a credit reference check may be taken with an authorised credit reference agency and/or my previous medical practice(s).
- I give my express permission for the Practice to request information including my medical records from my previously registered GP and I agree to reimburse the Practice for any charges and disbursements incurred relating thereto for the Practice being provided with such information.
- I understand it is my sole responsibility to advise the Practice in writing of any changes made in respect of my personal information.

Signed:	Print Full Name:	Dated:
Child Name:	Date of Birth:	

For Practice Use Only	On EMIS By:	☐ Secondary Registration ☐ Temporary	EMIS Number:

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FOR ITC USE ONLY

To be completed during consultation with Travel Clinic nurse.

A. Patient Details			
Full Name:			
Date of Birth:		EMIS ID:	
Travel Risk Assessment Performed? ☐ Yes ☐ No			

B. Travel Vaccines for This Trip					
Disease Protection	Vaccination Required	Vaccination Discussed	Vaccination Declined	Vaccine Given	Further Information
Cholera	☐	☐	☐	☐	
Dip/Tet/Polio	☐	☐	☐	☐	
Hepatitis A	☐	☐	☐	☐	
Hepatitis B	☐	☐	☐	☐	
Influenza	☐	☐	☐	☐	
Japanese B Encephalitis	☐	☐	☐	☐	
Meningitis ACWY	☐	☐	☐	☐	
MMR	☐	☐	☐	☐	
Rabies	☐	☐	☐	☐	
Tick-borne Encephalitis	☐	☐	☐	☐	
Typhoid	☐	☐	☐	☐	
Yellow Fever	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Travel Advice Leaflet Given as Per Travel Protocol: ☐ Yes ☐ No

C. Malaria Prevention Advice and Malaria Chemoprophylaxis

☐ Chloroquine and proguanil ☐ Atovaquone + proguanil (Malarone)

☐ Chloroquine ☐ Mefloquine ☐ Doxycycline ☐ Malaria advice leaflet given

Further Information: eg weight of Child:

Given by GP:	Date:

All pages of forms to be scanned to patient record in EMIS	Scanned Date:	