# Walton 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**