

## Cornerstone Practice Foreign Travel Form

The surgery provides a foreign travel vaccination service for all patients. To enable us to provide full vaccination immunity and travel advice we ask that whenever possible, you give us ample time to assess your needs and arrange appointments by completing & returning this form to us.

### How Long Before You Travel Should You Contact Us?

<b>European Travel</b>	<b>4 Weeks</b> Prior to Travel
<b>Multi Destination Travel</b> (Including cruises)	<b>8 Weeks</b> Prior to Travel

<b>Name &amp; Date of Birth</b>	
<b>Current Address</b>	
<b>Telephone Number</b>	
<b>Mobile Number</b>	

<b>Country &amp; Area/Region(s), Place to be Visited</b>	
<b>Reason for Travel</b>	
<b>Duration of Stay</b>	
<b>Date of Departure</b>	
<b>Accommodation</b>	Hotel/Hostel/Family Home/Camping

### Current & Previous Medical History

<b>Are you Pregnant?</b>	
<b>Known Allergies to Food or Drugs</b>	
<b>Medical Conditions</b>	Diabetes/Epilepsy/Heart Problems
<b>Current Medications</b> (including contraceptive pill)	

Thank you for your help, please return this form to the surgery; it will take about 4 working days for this form to be processed. Please re contact surgery after that date for an appointment. Please note that there is a charge for some vaccinations.

## Surgery Use Only

Date Form Returned to Surgery (Reception):	Emis Number:
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## Vaccines Recommended For This Trip

Vaccination	Date of Last Vaccination	Required	Certificate Given	Cost
Dip/Tet/Polio				
Hep A				
Typhoid				
Hep B				
Meningitis				
Yellow Fever				
Rabies				
Japanese Encephalitis				
Other				

Malaria Tablets	Advice Given	Prescription Given	OTC
Mefloquine			
Doxycycline			
Proguanil			
Chloroquine			
Atovaquone plus Proguanil			

Date Assessment Completed:	Initials (Clinician):
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I have read the above & have been given the opportunity to discuss any concerns. To the best of my knowledge there are no medical contraindications for me to receive the relevant vaccinations & I consent to the vaccinations being given.

Signed..... (Witnessed by nurse) Date.....