

ABBNEY MEAD SURGERY TRAVEL ASSESSMENT

To be completed by patient before their appointment.

NAME.....

Contact telephone number.....

Date of departure.....

Return date.....Length of trip.....

Itinerary and purpose of visit

- 1).....
- 2).....
- 3).....
- 4).....
- 5).....

Please list any other countries you may be visiting - day trips etc.

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Type of trip - Gap year/backpacking/cruise

Accommodation - Hotel/camping/family

Area - Urban/rural/altitude

Planned activities - safari/scuba diving etc.....

Are you near medical help (Y/N) or remote (Y/N)

FOR SURGERY USE

Travel advice leaflet given as per travel protocol (Y/N)

Malaria advice prevention and literature (Y/N)

Malaria chemoprophylaxis - given - see medical notes for details

- not required

- refused