Northgate Health Centre, Northgate, Bridgnorth, Shropshire, WV16 4EN Tel: 01746 767121 Fax: 01746 765433 Email: bridgnorth.medicalpractice@nhs.net www.bridgnorthmedicalpractice.co.uk



Bridgnorth Medical Practice provides the following NHS vaccinations: Hepatitis A/B, Diphtheria, Tetanus, Polio booster, Cholera, and Typhoid.

For other vaccinations, such as Rabies and Japanese Encephalitis, you may need to visit a travel center. Due to a shortage of Rabies vaccines, we may not always have them in stock. If Rabies vaccination is deemed necessary after your risk assessment, we will check stock availability and nurse availability to administer the doses on days 0, 7, and 21. If we cannot meet these requirements, you will be directed to a travel center.

Please book your travel vaccination appointment at least 6 weeks before your travel date to ensure we can accommodate your needs. If this is not possible, you may need to visit a travel center for additional vaccinations.

It is best practice for the nurse conducting your travel consultation to also administer your vaccinations.

TRAVEL RISK ASSESSMENT FORM – ideally to be completed by traveler prior to appointment.

Name:		Your country	of origin:	
		Date of birth	:	
		Male 🗆 Fe	emale 🗆	Non-binary □
E mail:		Telephone n	umber:	
		Mobile numl		
PLEASE SUPPLY INFORMATION A	ABOUT YOUR TRIP	IN THE SECTION	NS BELOW	
Date of departure:		Total length	of trip:	
COUNTRY TO BE VISITED	EXACT LOCATION O	R REGION	CITY OR RURAL	LENGTH OF STAY
1.				
2.				
3.				
What modes of transport will you	u be using?			
Have you taken out travel insura	nce for this trip?			
Do you plan to travel abroad aga	in in the future?			
TYPE OF TRAVEL AND DURDOSE	OF TRID - DI FACE 1	ICK VII THAT	ADDIV	

Partners

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	Holiday	☐ Staying in hotel	□ Backpa	cking		Additional information
	Business trip	☐ Cruise ship trip	☐ Campir	ng/host	els	
	Expatriate	□ Safari	□ Advent	ture		
	Volunteer work	□ Pilgrimage	☐ Diving			
	Healthcare worker	☐ Medical tourism	□ Visiting	g friends	/family	
PLI	ASE SUPPLY DETAILS	OF YOUR PERSONAL	MEDICAL I	HISTOR	Y	
PLI	ASE SUPPLY DETAILS	OF YOUR PERSONAL	MEDICAL I	HISTOR' YES	Y NO	DETAILS
	e you fit and well today		MEDICAL I			DETAILS
Are		У	MEDICAL I			DETAILS
Are	e you fit and well toda y allergies including fo	У				DETAILS

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Tendency to faint with injections	
Any surgical operations in the past, including e.g. open-	
heart surgery, spleen or thymus gland removal?	
Recent chemotherapy/radiotherapy/organ transplant	
Anaemia	
Bleeding /clotting disorders (including history of DVT)	
Heart disease (e.g. angina, high blood pressure)	
Diabetes	
Additional needs and/or disability	
Epilepsy/seizures (or in a first degree relative?)	
Gastrointestinal (stomach) complaints	
Liver and or kidney problems	
HIV/AIDS	
Immune system condition e.g. blood cancer	
Mental health issues (including anxiety, depression)	
Neurological (nervous system) illness	
Respiratory (lung) disease	
Rheumatology (joint) conditions	
Spleen problems	
Any other conditions?	
Are you or your partner pregnant or planning a	
pregnancy?	
Are you breast feeding (if applicable)	
Have you or anyone in your family undergone	
FGM / been cut	

Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?

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PLEASE SUPPLY INFORMATION	ON ANY VACCINES OR MALAR	RIA TABLETS TAKEN IN THE PAST
Tetanus/polio/diphtheria	MMR	Influenza
Typhoid	Hepatitis A	Pneumococcal
Cholera	Hepatitis B	Meningitis
Rabies	Japanese encephalitis	Tick borne encephalitis
BCG	Other	
COVID-19 (dates, brand etc.)		
Malaria Tablets		
Any additional information		