DISEASE PROTECTION	DOSES ADVISED	NHS OR PRIVATE HEALTH CLINIC	DOSES PER COURSE	ADVISED BY ADMIN	PATIENT DECLINED
Hepatitis A		COST COVERED BY NHS	2 DOSES 6-12 MONTHS APART		
Typhoid		COST COVERED BY NHS	1 DOSE LASTS 3 YEARS		
Tetanus/Polio/Diphtheria		COST COVERED BY NHS	5 PRIMARY DOSES THEN EVERY 10 YEARS		
MMR		COST COVERED BY NHS	2		
Cholera		NHS PRESCRIPTION	1		
Tick borne Encephalitis		PRIVATE TRAVEL CLINIC	2		
Hepatitis B		PRIVATE TRAVEL CLINIC	3-4		
Rabies		PRIVATE TRAVEL CLINIC	3		
Japanese Encephalitis		PRIVATE TRAVEL CLINIC	2		
Men ACWY		PRIVATE TRAVEL CLINIC	1		
Anti-Malaria Tablets		PRIVATE TRAVEL CLINIC	DEPENDENT ON TYPE		
Yellow Fever		NEEDS TO ATTEND YELLOW FEVER CENTRE– NOT AVAILABLE AT CHATSWORTH ROAD MEDICAL CENTRE	1		
Other					

Additional Practice Nurse Notes:

Chatsworth Road Medical Centre

Dr E. Riches
Dr D. Rash
Dr L. Scriven
Dr S. Lewis
Dr A. Galley
Dr S. Rackham
Dr A. Allaway

"Compassionate, Respectful Medical Care"

Storrs Road
Chesterfield
Derbyshire
S40 3PY
Tel: (01246) 568065
Fax: (01246) 567116
www.chatsworthroadmedicalcentre.nhs.uk

Travel Vaccination Advice

We ask that you allow 6-8 weeks before travelling to allow us time to book you in should you require any NHS vaccinations. If you are unable to do this, you may be asked to attend a private travel health clinic. Most vaccinations need at least 2 weeks prior to travel in order for you to build up immunity to the disease.

THE MORE INFORMATION YOU CAN GIVE US REGARDING YOUR TRAVEL PLANS THE MORE ACCURATE ADVICE WE CAN GIVE YOU.

PLEASE NOTE: ***WE WILL NOT BE ABLE TO PROCESS YOUR TRAVEL ENQUIRY WITHOUT ALL OF THE QUESTIONS BEING COMPLETED.***

DATE COMPLETED:……ACCEPTED BY:……

TO BE COMPLETED BY THE PATIENT:

NAME: DATE OF BIRTH:

ADDRESS:

PREFERRED CONTACT NUMBER:

IF MOBILE NUMBER ARE YOU HAPPY FOR US TO SEND YOU SMS IF THERES NO ANSWER? YES ( ) No ( )

Do you have any allergies? E.g.: eggs, antibiotics, nuts?

Have you ever had a reaction to a vaccine before?

Have you recently undergone radiotherapy, chemotherapy or steroid treatment, or been told you should not receive live vaccinations?

Women only: Are you pregnant or planning pregnancy/breastfeeding?

DETAILS OF YOUR TRIP:

DATE OF DEPARTURE:

DURATION OF STAY:

DESTINATION:

COUNTRY:

AREAS WITHIN COUNTRY YOU WILL BE VISITING:

TYPE OF ACCOMODATION:

LENGTH OF STAY IN EACH PLACE:

PLANNED ACTIVITIES / EXCURSIONS BOOKED:

Once you have completed the form, please return it to the surgery. The practice nurse will assess your travel risks and the practice will be in touch to arrange any relevant appointments. Please ensure you have good travel health insurance, and take any prescribed medication with you with proof of prescription.

FOR OFFICE USE ONLY

COMPLETED BY PRACTICE NURSE:

JS ☐ AW ☐ JR ☐

LENGTH OF APPOINTMENT REQUIRED: ☐ minutes

Actions taken:

Text sent via Accurx to book own appointment ☐

Patient informed by telephone ☐

Appointment Booked ☐

Date of Appointment _____

Referred to private travel clinic ☐