Pharmacy Use Only

Telephone Consultation	Consultation in Pharmacy	

PLEASE READ BEFORE COMPLETING FORM

Please complete ***Sections 1 to 9*** of the form and return to **Kepple Lane Dispensary / Pharmacy.** The pharmacist will review the information and make contact in **seven working days** to arrange a travel consultation.

Section 1 - Type of Travel Enquiry

Vaccination Enquiry		Malaria Enquiry		Vaccination Booster		Other Travel Enquiry	

Section 2 - Personal Details

Name		Male		Female	
Address					

Contact Tel/Mob	Date of Birth	NHS number (if known)
		GP / Surgery:
Email Address :		

Section 3 - Date of trip

Date of Departure	
Return Date or overall length of trip	

Section 4 - Details of Trip *additional paper can be used

Countries/Region/City to be visited	Length of stay	Countries/Region/City to be visited	Length of stay
1.		4.	
2.		5.	
3		6.	

Section 5 - Please tick as appropriate below to best describe your trip

Holiday Type	☐ Package Holiday	☐ Self-Organised Holiday	☐ Business Trip
	☐ Pilgrimage	☐ Long Term – Work / Charity	☐ Other
Accomodation	☐ Staying in Hotel	☐ Relatives / family home	☐ Hostel
	☐ Cruise Ship	☐ Camping	☐ Other
Travelling	☐ Travelling Alone	☐ Travelling with family/friends	☐ With Organised Group
	☐ Flying	☐ Train	☐ Car/Bus/Taxi
Planned Activities	☐Backpacking	☐ Altitude	☐ Adventure
	☐ Safari	☐ Voluntary/Charity Work	☐ Diving
	☐Trekking	☐ Tourist Activities	☐ Other

Section 6 - Medical History

Repeat prescribed medication Herbal / Holistic Medication				

Section 7 - Previous vaccinations if known

Polio	Expires	Tetanus	Expires	Diphtheria	Expires	Typhoid	Expires
Hepatitis A	Expires	Hepatitis B	Expires	Combined Hep A & B	Expires	Yellow Fever	Expires
Influenza	Expires	Rabies	Expires	Japanese B encephalitis	Expires	Tick-borne encephalitis	Expires
Cholera	Expires	Meningitis	Expires				

Other Vaccinations if not listed above:

Section 8 - Personal Details				
Name	Male		Female	
Address				
Contact Tel/Mob	Date of Birth	NHS number (if known) GP/Surgery		

Section 9 - The following questions will help us determine your eligibility to be vaccinated today				
1	Do you feel unwell today?	☐ Yes	☐ No	☐Don't know
2	Do you have any health conditions such as heart, diabetes or asthma?	☐ Yes	☐ No	☐Don't know
3	Do you have allergies to latex, medications, food or vaccines? (Examples egg, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thiomerosal)?	☐ Yes	☐ No	☐Don't know
4	Have you ever had a reaction after receiving an immunisation, including fainting or feeling dizzy?	☐ Yes	☐ No	☐Don't know
5	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillian-Barre Syndrome (condition that causes paralysis) or other nervous system problems?	☐ Yes	☐ No	☐Don't know
6	**For Women Only:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐Don't know
7	Have you received any vaccinations or skin tests in the past four weeks? If yes, please list : ______________________________	☐ Yes	☐ No	☐Don't know
8	Do you have a condition that may weaken your immune system (e.g. cancer, leukaemia, lymphoma, HIV/AIDs, transplant?	☐ Yes	☐ No	☐Don't know
9	Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) and Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐ Yes	☐ No	☐Don't know
10	Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	☐ Yes	☐ No	☐Don't know
11	Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed?	☐ Yes	☐ No	☐Don't know
12	Are you currently taking any antibiotics or antimalarial medications?	☐ Yes	☐ No	☐Don't know
13	Do you have a history of thrombocytopenia or thrombocytopenia purpura?	☐ Yes	☐ No	☐Don't know

- I certify that I am: the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient.
- Further, I hereby give my consent to the healthcare provider Kepple Lane Pharmacy T/A Garstang Medical Services Ltd to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s).
- I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me that I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- That the information obtained for the consultation is accurate and correct to the best of my knowledge.
- I also agree that this information can be shared with my doctor (GP)
- I also agree that prior to the consultation access to my NHS medical records may be required to ensure an accurate assessment.
- Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider.

Signature………………………………………………………………………………….Date…………………………………………………………………….

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Date Received				Staff initials			
Payment Received	Amount			Card	Cash		
Patient contacted – Yes / No	*Time*	*Day*	*Month*	Unable to contact patient first attempt	*Time*	*Day*	*Month*
Voicemail left?	*Time*	*Day*	*Month*	Unable to contact patient second attempt	*Time*	*Day*	*Month*
Appointment booked	*Time*	*Day*	*Month*				
Additional Information							

To be completed by the Pharmacist Only

Patient Name

Travel Consultation performed by	Name	Time	Date

Travel Vaccinations recommended for this trip

***Key – *R – Recommended *SA – Sometimes Advised *HR – High Risk Traveller**

Vaccination	R	SA	HR	Booster / Revaccination Date	Further information
Hepatitis A					
Hepatitis B					
Hepatitis A & B Combined					
Typhoid					
Tetanus/Diptheria/Polio					
Yellow Fever					
Rabies					
Cholera					
Japanese B Encephalitis					
Meningitis ACWY					
Tick-Borne Encephalitis					
MMR					

Others

Pharmacy Use only

To be completed by the Pharmacist Only
Complete before any vaccines are administered

1	I have reviewed the Patients Information and Screening Questions		
2	This is the vaccine(s) requested and agreed by the patient		
3	The vaccine(s) are appropriated for the patient and meet all requirements as per Greenbook / Nathnac / Travax		
4	The patient has confirmed Name, DOB and consented to administration of vaccine(s)		
5	Relevant information provided to patient prior to vaccination		
6	Additional Information:		

Vaccinations administered

Vaccination	Brand	Location / IM / SC	Batch No/Exp Date	Other info

Malaria prevention advice and chemoprophylaxis

Risk to travellers

High Risk		**Low Risk with additional advice**		**Low to no risk**	
Chemoprophylaxis					
Atovaquone & Proguanil		**Chloroquine & Proguanil**		**Mefloquine**	
Doxycycline		**Chloroquine**		**Low Risk/ Advice**	

Other Comments / Advice / Contra-indications