**SHOTFIELD MEDICAL PRACTICE**

**Travel Vaccination Policy and Enquiry Form**

This is for use when patients are travelling abroad with advanced notice. Patients will be asked to complete an enquiry form usually about 6-8 weeks prior to their travel. This notice period allows sufficient time to offer advice, make relevant appointments and ensure the patient is adequately covered before they travel.

Once the form has been completed in full the patient will be asked to make an appointment with the nurse. The details of this appointment should be written on the top of the form and the form left in the nurse’s tray for them to retrieve and examine prior to the appointment. **Do not** make same day appointments for travel advice or vaccinations. The nurse will review the form and check the patient record and may contact the patient if she requires anything further before the appointment. If no vaccinations are required the nurse will advise the patient of this.

Please note there are charges for some vaccinations and details of these charges are available at reception or from the nurse.

Payment is required by card, cash or cheque (payable to Shotfield Medical Practice).

Certificate of vaccination (if required) is charged at £15.00. Lost certificates will incur a £15.00 fee to issue a new certificate of vaccination. Certificates will only be issued for those vaccinations given by the practice.

All travel vaccine costs (including courses) requirement payment in full when the first dose is given. Vaccinations will not be given without full payment being made at the first appointment.

***Important: please note that if you pay the fee and do not complete the course or do not have the private prescription dispensed no refund will be made to you for fees incurred by the practice for the completion of prescriptions or the ordering of vaccines.***

If you are going abroad at short notice we may not have a suitable appointment to offer you within the required time frame. If this happens you should consider seeking the services you require from another provider. Please ask at reception for details of other providers.

When we make your first travel appointment this is a **double appointment** with a suitably qualified nurse. If you fail to attend this appointment without giving sufficient notice to the practice so it can be offered to another patient then we will not re-book you again for travel advice or vaccinations here in the following 3 month period. If this happens, you would be referred to a local travel clinic for any further needs at that time.

For further information please also visit http://www.fitfortravel.nhs.uk/

**Please see below details of charges that apply as at January 2025***.*

**SHOTFIELD MEDICAL PRACTICE**

**CHARGES TO OUR PATIENTS FOR TRAVEL**

**Meningitis ACWY (with certificate of vaccination)**

Single dose 2-3 weeks before travel, covers 5 year £ 70.00

**Rabies - course of 3**

2nd dose 7 days after 1st dose,

3rd dose 21-28 days after 1st dose £95 per dose

**Japanese B Encephalitis - course of 2 - ordered in on request only**

2nd dose 28 days after 1st dose (over 18’s only) £240.00 for 2

**Hepatitis B (for travel only) - course of 3**

2nd dose 1 month after 1st dose

3rd dose 5 months after 2nd dose £55.00 per dose

**Cholera – 2 doses**

More than 1 week and less than 6 weeks apart by NHS prescription. **NHS Prescription**

You must complete course at least 1 week prior to travel,

collect and pay any appropriate dispensing fee

**Typhoid Free**

Single dose at least 1 month prior to travel

**Hepatitis A Free**

Single dose at least 2 weeks prior to travel

**Diptheria, Tetanus and Polio Free**

3 doses 1 month apart

Certificate of vaccination (if required) £15.00

All travel vaccine costs (including courses) requirement payment **in full** when the first dose is given. Vaccinations will not be given without full payment being made at the first appointment.

All fees are payable at reception and will be receipted.

*Important: please note that if you pay a private fee and do not complete the course or do not have the private prescription dispensed no refund will be made to you for fees incurred by the practice for the completion of prescriptions or the ordering of vaccine*

**SHOTFIELD MEDICAL PRACTICE**

Jubilee Health Centre, Shotfield, Wallington, Surrey SM6 0HY

Tel No. 020 8669 7612

Website: [www.shotfieldmedicalpractice.co.uk](http://www.shotfieldmedicalpractice.co.uk)

**Travel risk assessment and enquiry form** – to be completed by the traveller 6-8 weeks prior to travel and prior to an appointment being made with the nurse (see details above)

**PLEASE COMPLETE IN FULL AND IN BLOCK CAPITALS**

Full Name: ……………………………………………………………………………………………

Address: ……………………………………………………………………………………………...

…………………………………………………………………………………………………………

Date of Birth: ……………………………………… Male / Female\*

Contact Tel. Home: ……………………….….….. Mobile: …………………………………….

Date of Departure: ……………………………. Total Duration of Trip: ………………………..

|  |  |  |  |
| --- | --- | --- | --- |
| Country to be visited | Exact location of region | City or rural area | Length of stay |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you taken travel insurance for this trip? Yes / No\*

Do you plan to travel abroad again in the future? Yes / No\*

Type of travel and purpose of trip – **please delete any that do not apply**

Holiday Business Trip Expatriate Volunteer Work Healthcare Worker

Staying in Hotel Cruise Ship Safari Pilgrimage Medical Tourism

Backpacking Camping/Hostel Adventure Diving Visiting Family/Friends

Any additional information about your trip? ………………………………………………………………...

|  |  |  |  |
| --- | --- | --- | --- |
| **Please provide details about your personal medical history below:** | | | |
|  | Yes | No | Details |
| Are you fit and well today? |  |  |  |
| Do you suffer from any allergies including food, latex or medication |  |  |  |
| Have you had a severe reaction to a vaccination before? |  |  |  |
| Do you have a tendency to faint after a vaccination? |  |  |  |
| Have you had any surgical operations in the past including your spleen or thymus gland being removed? |  |  |  |
| Had you undergone recent chemotherapy, radiotherapy or organ transplantation? |  |  |  |
| Do you suffer from anaemia? |  |  |  |
| Do you suffer from any bleeding or clotting disorders (including history of DVT)? |  |  |  |
| Do you suffer from heart disease (including high blood pressure or angina)? |  |  |  |
| Are you a diabetic? |  |  |  |
| Do you have a disability? |  |  |  |
| Do you suffer from epilepsy or seizures? |  |  |  |
| Do you suffer from any gastrointestinal (stomach) complaints? |  |  |  |
| Do you suffer from any liver and/or kidney problems? |  |  |  |
| Do you have HIV or AIDS? |  |  |  |
| Do you have any condition affecting your immune system? |  |  |  |
| Do you suffer from any mental health issues (including anxiety or depression)? |  |  |  |
| Do you suffer from any neurological (nervous system) illness? |  |  |  |
| Do you suffer from any respiratory (lung) disease? |  |  |  |
| Do you suffer from any rheumatologic (joint) conditions) |  |  |  |
| Do you have any spleen problems? |  |  |  |
| Do you have any other conditions? |  |  |  |
| **WOMEN ONLY** |  |  |  |
| Are you pregnant? |  |  |  |
| Are you breast feeding? |  |  |  |
| Are you planning a pregnancy whilst away? |  |  |  |

|  |
| --- |
| **Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)? If yes, please give details of all below:** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please provide details of vaccinations received or malaria tablets taken in the past below:** | | | | | |
| Tetanus/polio/diptheria |  | MMR |  | Influenza |  |
| Typhoid |  | Hepatitis A |  | Pneumococcal |  |
| Cholera |  | Hepatitis B |  | Meningitis |  |
| Rabies |  | Japanese Encephalitis |  | Tick Borne Encephalitis |  |
| Yellow Fever |  | BCG |  | Other: | |
| Malaria Tablets |  | | |

**Any other relevant information: …………………………………………………………………………**

**……………………………………………………………………………………………………...................**

**\*delete as appropriate Form Version HS Jan 2025**