CHURCH LANGLEY MEDICAL PRACTICE

YELLOW FEVER PRE-VACCINATION FORM (PATIENT SPECIFIC DIRECTION) (ALSO RABIES, TICK BORNE ENCEPHALITIS, MENINGITIS ACWY)

Please complete this form and return to the surgery prior to attending for vaccination. The yellow fever certification must be issued 10 days prior to travel for it to be valid.

PERSONAL DETAILS

Name: Easiest contact number:	Date of birth / / Male❑ Female❑

DATES OF TRIP

Date of departure / /	Return date / /

ITINERARY AND PURPOSE OF VISIT

Countries with destinations to be visited	**Length of stay**
1)	
2)	
3)	

DESCRIBE YOUR TRIP **(Please tick as many as you feel are appropriate)**

❑ Business ❑ Pleasure ❑ Other

❑ Package ❑ Self organised ❑ Backpacking ❑ Camping ❑ Cruise ship

❑ Hotel ❑ Relatives/friends home ❑ Other

Travelling ❑ Alone ❑ With family/friend ❑ In a group

Staying in an area ❑ Urban ❑ Rural ❑ Altitude

Planned activities ❑ Safari ❑ Adventure ❑ Other

PERSONAL MEDICAL HISTORY

Do you have any illnesses? *If **YES** please give details*

Are you taking any medication(s)? *If **YES** please give details*

Do you have any allergies for example to eggs, antibiotics, nuts or latex? *If **YES** please give details*

Have you ever had a serious reaction to a vaccine given to you before? *If **YES** please give details*

Have you had any steroid, chemotherapy or immunosuppressant drugs (i.e. Methotrexate/Cyclosporin / Azathioprine? *If **YES** please give details*

Women only: Are you pregnant or planning pregnancy or breastfeeding? *If yes please give details*

VACCINATION HISTORY IF ***NOT RECEIVED HERE AT THE PRACTICE***

Have you ever had any travel vaccinations or malaria tablets from elsewhere? If so what and when? .....

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PATIENT DECLARATION

I wish to be vaccinated against yellow fever / rabies / tick borne encephalitis / meningitis / ACWY (delete as necessary). I understand there is a charge for this vaccination as this is not part of the NHS provision.

I have had the opportunity to discuss the suitability and side effects of the vaccine(s).

Patient Signature: _____ Date: _____

FOR PRACTICE NURSE USE ONLY Travel risk assessment performed ❑ Yes ❑ No

VACCINES	*In Date*	*Recommend*	*Consider/ Risk Awareness*	*Vaccine Schedule*	*Dose*	*Cost per vaccine*
Hepatitis A				2 doses total 0 and 6-12 months		Exempt
Hepatitis B				0, 1, 6 months (3 doses) ***OR*** 0, 1, 2 months (booster 1 yr) OR 0, 7, 21 days (booster 1 yr)	ENGERIXB 20mcg/ml	£155.00 course of 3 see charges
Typhoid				Single dose 3 yearly		Exempt
Cholera				Oral preparation 0 and 2-6 weeks	Dukoral 2 sachets	Prescription charge
Tetanus/Dip/Polio				Single dose 10 yearly		Exempt
Meningitis ACWY				Single dose	Menveo 0.5ml	£50.00
Yellow Fever				Single dose	Stamaril 0.5ml	£55.00
Rabies				3 doses 0, 7 and 21-28 days	Rabipur 1ml Rabies Vaccine 1ml	£135.00
Japanese B Encephalitis				2 doses 0 and 28 days	Ixiaro 0.5ml	£15.00

Comments……

MALARIA PREVENTION AND ADVICE

	Suitable	Dose per week
Chloroquine and proguanil		2 tablets weekly starting 1 week before, during and for 4 weeks after trip
Chloroquine		2 tablets weekly starting 1 week before, during and for 4 weeks after trip
Doxycycline		Daily starting 1 week before, during and for 4 weeks after trip
Malarone		Daily starting 2 days before, during and for 7 days after trip
Malarone Paediatric		Daily starting 2 days before, during and for 7 days after trip
Mefloquine		Weekly starting 2 weeks before, during and for 4 weeks after trip
Mosquito bite avoidance		

Comments……

APPOINTMENTS REQUIRED FOR:	**No. of Appts**	**Duration**
Vaccination ❑ Discuss requirements ❑ Malaria advice ❑		

PATIENT SPECIFIC DIRECTION (PSD)

Administration by Practice Nurse:

Patient risk assessment performed and authorised by:

Prescribers name (Dr) **Signature** **Date / /**

Date completed by Nurse: _____ Signed: _____