

# Malaria | Travel Risk Assessment Form

Date: \_\_ / \_\_ / 20 \_\_

Patient's personal details	
Title: Mr: <input type="checkbox"/> Miss: <input type="checkbox"/> Ms: <input type="checkbox"/> Mrs: <input type="checkbox"/> Dr: <input type="checkbox"/>	Patient Address:
First Name:	NHS No. (if known):
Last Name:	GP Name and Address:
Telephone:	GP Telephone (if known):
Gender: Male: <input type="checkbox"/> Female: <input type="checkbox"/> D.O.B: ____ / ____ / ____	Age: <input type="text"/>
Would you like us to send a copy of this consultation to your GP? <input type="checkbox"/>	

Dates of Trip
Date of departure
Return date or overall length

Itinerary and purpose of visit			
Coutry to be visited	Mode of Transport	Length of Stay	Remote? Trek? Medical access? Altitude?
1.			
2.			
3.			
4.			
5.			
6.			

Personal Medical History			
Tick which of the following applies to you...	Yes	No	Details (to be reconfirmed at each appointment)
Do you have any recent or past medical history of note?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any current or repeat medicines?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any allergies to any medicines?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a serious reaction to any antimalarial or doxycycline before?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you know if you are hypersensitive to mefloquine or related compounds (e.g. quinine, quinidine) or excipients?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you suffer from any blood disorders such as thalassaemia or sickle cell anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a past history of black water fever?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have severe impairment of liver or kidney function?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking halofantrine?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you currently suffer or have suffered, at any time from depression, generalised anxiety disorder, psychosis, schizophrenia, suicide attempts, suicidal thoughts, self-endangering behaviour or and other psychiatric disorder, epilepsy or convulsions of any origin?	<input type="checkbox"/>	<input type="checkbox"/>	

Women Only			
Tick which of the following applies to you...	Yes	No	Details (to be reconfirmed at each appointment)
Are you pregnant or planning a pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	

**Write below any further information which may be relevant e.g. medicines taking, conditions, concerns...**

## For Official Use

Initial Consultation					
Date	Malaria Prophylactic Medicine	Quantity	Details	Price	
	Malarone or Atovaquone + Proguanil				
	Lariam or mefloquine				
	Doxycycline				
	Paludrine or chloroquine + proguanil				
	Chloroquine				

  

Additional Travel Advice					
Water and personal hygiene	<input type="checkbox"/>	Travellers' diarrhoea	<input type="checkbox"/>	Hepatitis B and HIV	<input type="checkbox"/>
Insect bite prevention	<input type="checkbox"/>	Animal bites	<input type="checkbox"/>	Medicine side effects	<input type="checkbox"/>
Insurance	<input type="checkbox"/>	Air travel	<input type="checkbox"/>	Sun and heat protection	<input type="checkbox"/>

### PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment\*.

Patient Name / signature ...../ ...../ ..... Date.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? Yes / No

### PHARMACIST AGREEMENT

I have consulted the specific PGD which enables me to supply the listed medicine and have found that the patient is included in treatment and there are no valid exclusions applicable. I have given the patient information on the risks and benefits of the medicines recommended and have done my utmost to ensure the patient fully understands them. I have also given the patient the opportunity to ask questions. This will be carried out at each appointment.

Pharmacist Name / signature ...../ ...../ ..... Date.....

## Record of Treatment Provision

*New risk assessment form required after 4 consultations*

For each follow up consultation					
Medicine Supplied	Quantity	Details	Change in medical history	Pharmacist Signature	Price
No.1			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Patient Signature			Date		
No.2			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Patient Signature			Date		
No.3			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Patient Signature			Date		
No.4			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Patient Signature			Date		