Malaria | Travel Risk Assessment Form

Date: _ _ / _ _ / 2 0 _ _

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

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?	☐	☐	
Do you take any current or repeat medicines?	☐	☐	
Do you have any allergies to any medicines?	☐	☐	
Have you had a serious reaction to any antimalarial or doxycycline before?	☐	☐	
Do you known if you are hypersensitive to mefloquine or related compounds (e.g. quinine, quinidine) or excipients?	☐	☐	
Do you suffer from any blood disorders such as thalassaemia or sickle cell anaemia?	☐	☐	
Do you have a past history of black water fever?	☐	☐	
Do you have severe impairment of liver or kidney function?	☐	☐	
Are you taking halofantrine?	☐	☐	
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?	☐	☐	

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?	☐	☐	
Are you breastfeeding?	☐	☐	

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

For Offical Use

Initial Consultiation

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	☐	Travellers' diarrhoea	☐	Hepatitis B and HIV	☐
Insect bite prevention	☐	Animal bites	☐	Medicine side effects	☐
Insurance	☐	Air travel	☐	Sun and heat protection	☐

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 ☐ No ☐		
Patient Signature			Date		
No.2			Yes ☐ No ☐		
Patient Signature			Date		
No.3			Yes ☐ No ☐		
Patient Signature			Date		
No.4			Yes ☐ No ☐		
Patient Signature			Date		