We offer all necessary travel vaccines, general advice on travel and malaria prophylaxis.

Whilst some travel vaccines are available free on the NHS, we charge for other vaccines and travel services.

Travel requirements are constantly changing and especially due to Covid-19. Please check the FCDO website for regular updates. You should follow the latest UK guidance on measures you need to take upon your return to the UK including instructions regarding self-isolation (quarantine).

**Travel Clinic**

1. **Collect a travel form from reception or download from website**
2. **Hand in at reception or email (**[**reservoir.roadsurgery@nhs.net**](mailto:reservoir.roadsurgery@nhs.net)**)**
3. **A telephone consultation will be made for you to discuss the required travel vaccinations.**
4. **An appointment will be made for you to see the nurse face to face to administer the vaccinations.**

It is important to make this initial appointment as early as possible - at least 6 weeks before you travel- as a second appointment will be required with the practice nurse to actually receive the vaccinations.

Your second appointment needs to be at least 2 weeks before you travel to allow the vaccines to work.

\*\*Please note due to covid-19, we are expecting some delays and waiting times to see a nurse could be up to 4 weeks or more\*\*

We have listed some alternative travel clinics nearby:

Superdrug Health Clinic

Unit 1 100, 94 High St, Erdington, Birmingham B23 6RS

Phone: 0333 311 1007

Sutton Coldfield Travel Clinic

Oakley Partnership  
52 Bishops Way  
Sutton Coldfield  
West Midlands  
B74 4XS

Phone: 0121 308 8876

MASTA Travel Clinic - Lloyds Pharmacy

My Local Travel Clinic

Laser Pharmacy, 854 Stratford Rd, Springfield, Birmingham B11 4BS

Phone: 0121 778 2921

416 Birmingham Road  
Wylde Green

B72 1YJ  
Phone: 0330 100 4106

**PATIENT FORM FOR TRAVEL VACCINATIONS**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | | | | | | |
| Name: | | | | | Date of Birth:  Male [ ] Female [ ] | | | | |
| Easiest Contact Number: | | | | | | | | | |
| Email: | | | | | | | | | |
| **Dates of Trip** | | | | | | | | | |
| Date of Departure: | | | | | | | | | |
| Return date or overall length of trip: | | | | | | | | | |
| **Itinerary & purpose of visit** | | | | | | | | | |
| Country to be visited | | Length of stay | | | | Away from medical help at destination, if so, how remote? | | | |
| 1. | |  | | | |  | | | |
| 2. | |  | | | |  | | | |
| Future travel plans | |  | | | |  | | | |
|  | |  | | | |  | | | |
| **Please tick as appropriate below to best describe your trip** | | | | | | | | | |
| 1. Type of trip | Business | |  | Pleasure | | |  | Other |  |
| 2. Holiday type | Package | |  | Self organised | | |  | Backpacking |  |
| Camping | |  | Cruise ship | | |  | Trekking |  |
| 3. Accommodation | Hotel | |  | Relatives/family home | | |  | Other |  |
| 4. Travelling | Alone | |  | With family/friend | | |  | In a group |  |
| 5. Staying in an area which is | Urban | |  | Rural | | |  | Altitude |  |
| 6. Planned activities | Safari | |  | Adventure | | |  | Other |  |
| **Personal Medical History** | | | | | | | | | |
| Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions) | | | | | | | | | |
| List any current or repeat medications | | | | | | | | | |
| Do you have any allergies for example to eggs, antibiotics, nuts? | | | | | | | | | |
| Have you ever had a serious reaction to a vaccine given to you before? | | | | | | | | | |
| Does having an injection make you feel faint? | | | | | | | | | |
| Do you or any close family members have epilepsy? | | | | | | | | | |
| Do you have any history of mental illness including depression or anxiety? | | | | | | | | | |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | | | | | | | | | |
| **Women only**: Are you pregnant or planning pregnancy or breast feeding? | | | | | | | | | |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company? | | | | | | | | | |
| Please write below any further information which may be relevant | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccination History** | | | | | |
| Have you ever had any of the following vaccinations / malaria tablets and if so when? | | | | | |
| Tetanus |  | Polio |  | Diphtheria |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | Tick Bone |  |
| Other | | | | | |
| Malaria tablets | | | | | |

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccinations being given:

Signed:……………………………………………………………………………………Date:……………………………………

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FOR OFFICIAL USE**  **Receptionist to code: ‘recommend travel vaccinations’ and free text ‘form completed in travel clinic request folder’** | | | | | | |
| Patient Name: | | | | | | |
| Travel risk assessment performed: Yes [ ] No [ ] | | | | | | |
| Travel Vaccines recommended for this trip | | | | | | |
| **Disease protection** | **Yes** | **No** | **Further information** | | | |
| Hepatitis A |  |  |  | | | |
| Hepatitis B |  |  |  | | | |
| Typhoid |  |  |  | | | |
| Cholera |  |  |  | | | |
| Tetanus |  |  |  | | | |
| Diphtheria |  |  |  | | | |
| Polio |  |  |  | | | |
| Meningitis ACWY |  |  |  | | | |
| Yellow Fever |  |  |  | | | |
| Rabies |  |  |  | | | |
| Japanese B Encephalitis |  |  |  | | | |
| Other |  |  |  | | | |
| **Travel advice and leaflets given as per travel protocol** | | | | | | |
| Food water & personal hygiene advice |  | Travellers’ diarrhoea | |  | Hepatitis B & HIV | |
| Insect Bite prevention |  | Animal bites | |  | Accidents | |
| Insurance |  | Air travel | |  | Sun & heat protection | |
| Websites | | Travel Record card supplied | | | | |
| Other | | | | |
| **Malaria prevention advice and malaria chemoprophylaxis** | | | | | | |
| Chloroquine and proguanil | |  | Atovaquone + proguanil (Malarone) | | |  |
| Chloroquine | |  | Mefloquine | | |  |
| Doxycycline | |  | Malaria advice leaflet given | | |  |
| **Further information** | | | | | | |
| eg weight of child: | | | | | | |
| **Authorised for Patient Specific Direction (PSD) Use** | | | | | | |
| Name: Signature: Date: | | | | | | |