**Croft Hall Medical Practice 2019**

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| **Travel Risk Assessment Form**Name: Date of birth: Telephone:Address: Alternative Telephone: Email: |
| **Travel Details:** |
| Departure Date:Return Date:  | Total Length of Trip:  |
| **Country/Destinations** | **Region** | **Length of Stay** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
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| **Purpose of Trip:**Adventure/Gap year: Aid work/Emergency response: Business/Work trip: Charity/Volunteer: Cruise: Diving: Health worker Holiday: Long term/Expatriate: Medical treatment: Pilgrimage: Visiting friends and family: Other:  |

**Women only** Are you pregnant, breastfeeding or planning pregnancy whilst travelling? Yes No  |
| **Babies and Children Only:**Current weight: Date: |
| **Do you have current travel health insurance?**Yes No  |
| **Any other appropriate information or further details, please provide below:** |

Questions and information accessed from Travel Health Pro. Available from: <https://travelhealthpro.org.uk/media_lib/mlib-uploads/full/example-risk-assessment-risk-management-checklist-2018.pdf>