Sonic HealthPlus | IPN Medical Centres | Travelvax Complete Travel Health Service

Travel Health Plan

Travel Health Plan Disclaimer: *Please ensure all relevant information is provided. Travelvax and its partner clinicians and agents shall not be liable for any advice or treatment provided based on incorrect or incomplete information.*

PERSONAL DETAILS		
Surname:	First Name:	
D.O.B:	Telephone No:	
Address:		Postcode:
Email:		
Employer:	Occupation:	
Medicare Number:		
Source of Referral:		
Emergency Contact:	Phone No:	Are you of Aboriginal or Torres Strait Islander decent? ☐ Y/N ☐

TRAVEL & HEALTH PROFILE	YES	NO
Do you have a fever or illness at present?	☐	☐
Have you been a patient in hospital in the last 6 weeks?	☐	☐
Do you suffer from any disease e.g.; Diabetes, bleeding disorder, heart disease including heart rhythm disorders?	☐	☐
Are you taking any medications? Please list:	☐	☐
Have you received a blood transfusion or immunoglobulin in the past 12 months?	☐	☐
Do you have HIV, an immune disorder or cancer? Have you had cancer treatment or chemotherapy?	☐	☐
Have you been treated with steroids recently (e.g. Prednisolone)?	☐	☐
Have you had any vaccinations in the last month?	☐	☐
Do you suffer from any allergies? Please list:	☐	☐
Have you ever had any reaction to a vaccination or are you allergic to latex or any preservatives in vaccines?	☐	☐
Are you currently breast-feeding, pregnant or planning to become pregnant during your trip?	☐	☐
Have you ever had hepatitis?	☐	☐
Have you had a thymectomy, thymus disease, history of Myasthenia Gravis or DiGeorge syndrome?	☐	☐
Have you had a splenectomy (spleen removed)?	☐	☐
Have you ever been diagnosed with Guillain-Barre Syndrome?	☐	☐
Have you ever had epilepsy or seizures?	☐	☐
Have you required treatment for depression, anxiety or other psychiatric problems?	☐	☐
Are you prone to heartburn, peptic ulcers or indigestion?	☐	☐
Have you had any Achilles tendon problems?	☐	☐
Have you ever had altitude sickness?	☐	☐
Are you prone to thrush (candida)?	☐	☐
Have you ever felt faint after an injection or giving blood?	☐	☐
Are you especially scared of needles?	☐	☐

INFORMATION ABOUT YOUR TRIP	
Reason for Travel:	
Departure Date:	Return Date:

COUNTRIES/REGIONS IN ORDER OF VISIT	DURATION: DAYS/WEEKS/MONTHS	TYPE OF ACCOMMODATION TENT/HOSTEL/HOTEL/TRANSIT	ENVIRONMENT: URBAN/RURAL/ALTITUDE
1.			
2.			
3.			
4.			
5.			
Name of work site (if applicable)			

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Name _____ Date of Birth _____

VACCINATION RECOMMENDATIONS

VACCINE	CURRENT	ADMINISTER	DECLINED	RN SIGN	DATE ADMINISTERED / BATCH #		
IPOL							
TETANUS / DIPHTHERIA							
dTpa – Adult							
dTpa IPV – Adult							
MMR							
CHICKENPOX							
HEP A - Adult							
HEP A - Paediatric							
HEP B - Adult							
HEP B - Paediatric							
TWINRIX - Adult							
TWINRIX - Paediatric							
TYPHOID - IM							
TYPHOID - Oral							
HEP A & TYPHOID							
CHOLERA							
YELLOW FEVER							
JAPANESE ENCEPHALITIS							
RABIES							
MENINGITIS ACWY							
MENINGITIS C							
INFLUENZA							

MALARIA			OTHER PRESCRIPTION MEDICATIONS		
IS MALARIA A RISK?	☐ YES	☐ NO	MALARIA SELF-TREATMENT	☐ YES	☐ NO
PERIOD OF EXPOSURE		DAYS	ALTITUDE PROPHYLAXIS	☐ YES	☐ NO
PROPHYLAXIS MEDICATION	ADMINISTER	QTY	TREATMENT MEDICATION	ADMINISTER	QTY
Doxycycline 100mg x 21 caps			**Malarone** 250mg x 12 tabs		
Doxycycline 100mg x 7 caps			**Riamet** 20mg +120mg x 24 tabs		
Malarone 250mg x 12 ***or*** 24 tabs (select option)			**Diamox** 250mg x 10 tabs		
Malarone 250mg x 1 tab			**Norfloxacin** 400mg x 6 tabs		
Malarone Junior 62.5mg x 12 tabs			**Azithromycin** 500mg x 3 tabs		
Malarone Junior 62.5mg x 1 tab			**Fasigyn** 500mg x 4 tabs		
Lariam 250mg x 8 tabs			**Stemetil** 5mg x 20 tabs		
COMMENTS:					

FIRST AID KITS AND ACCESSORIES

FIRST AID KITS				RX KITS		ACCESSORIES			
REC 1		PRO 1		RX 1/+		REPEL Adult		PERMETHRIN	
REC 2		PRO 2		RX 2/+		REPEL Junior		H_2O PURIFIER	
REC 3		PRO 3		RX 3/+		MOSI-GUARD		OTHER	
OTHER						PICARIDIN			

☐ **Mantoux PPD Tuberculosis Testing**	
Date:	
Reading:	
Quantiferon Gold result:	

REVIEW

TRAVEL HEALTH EDUCATOR					
NAME		**DESIGNATION**		**DATE**	
MEDICAL PRACTITIONER					
NAME (print)		**NAME** (sign)		**DATE**	
FOLLOW-UP MEDICAL PRACTITIONER					
NAME (print)		**NAME** (sign)		**DATE**	
FOLLOW-UP MEDICAL PRACTITIONER					
NAME (print)		**NAME** (sign)		**DATE**	

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DOCTOR OR NURSE TO COMPLETE

HEALTH RISKS COVERED				LIVE VACCINE CHECKLIST			IMMUNOCOMPROMISED		
					YES	NO		YES	NO
Diarrhoea	☐	High Altitude	☐	Egg allergy	☐	☐	Chemotherapy	☐	☐
Safe eating/drinking	☐	STIs	☐	Pregnant / Breastfeeding	☐	☐	Radiotherapy	☐	☐
Malaria	☐	Thrombosis	☐	Other live vaccines <4 weeks	☐	☐	HIV/AIDS	☐	☐
Insect-borne	☐	Culture shock	☐	Fever / Illness	☐	☐	Autoimmune disease	☐	☐
Rabies	☐			Blood or blood products within 12 mo	☐	☐	Immunosuppressive drugs	☐	☐
Schistosomiasis	☐			Immunocompromised (see next column)	☐	☐	Other	☐	☐
Comments:							Investigations and vaccine recall details:		
☐ Tropimed report given									

Doctor's Signature_____ Date_____ Stamp _____

VACCINE CONSENT

With all vaccines there is a risk of adverse reactions. Serious allergic reactions are rare and generally occur within 30 minutes of vaccination.
You may be required to wait on the premises for up to 30 minutes after vaccination for this reason. Less severe side effects may include:

- Localised tenderness, redness, swelling and irritation at the injection site.
- Mild fever and headache lasting a short period of time
- Mild gastrointestinal symptoms including abdominal pain and nausea
- More serious reaction are very rare, less than 1 in 10 000 injections

I have received information regarding the need for vaccination, contraindications to receiving vaccines, possible side effects and potential adverse reactions to the recommended vaccines, and I am consenting to receive the above listed vaccinations.

Name_____ Signature_____ Date _____

DECLARATION (CORPORATE REFERRALS ONLY)

Please read the following and sign where indicated

Declaration - I declare that I have answered the above correctly and completely, to the best of my knowledge. I understand that any false or misleading information may result in disciplinary action, up to and including termination of employment.

Statement authorisation - I hereby authorise Sonic Health*Plus* and the examining doctor to release any information acquired, collated or ascertained as a result of the examination and consultation to my employer, prospective employer or their authorised representative.
I also acknowledge that the findings of this examination may be used by my employer, prospective employer or their authorised representative in relation to my employment.

Did you receive any assistance by another person to complete this form? ☐ Yes ☐ No

If Yes: provide details

Name_____ Signature_____ Date _____

Travel Health Plan

OFFICE USE ONLY (FOR REQUESTING CORPORATE COMPANIES/CLIENTS ONLY)

Assessment details	
(Candidate name)	
was assessed on	
proposed travel to	
employed in position of	

The following assessments have been completed and reviewed:

	Satisfactory	Other	N/A		Satisfactory	Other	N/A
Medical history	☐	☐	☐	Audiometry	☐	☐	☐
Medical examination	☐	☐	☐	Spirometry	☐	☐	☐
Drug Screening has been completed (Only if specifically requested by employer)						Yes ☐	No ☐
Result of Drug Screen has been interpreted at the request of the client (Medical Review Officer Services)						Yes ☐	No ☐

☐	**Fit** to travel safely
☐	Is **Fit** to safely travel to and work in the proposed location.
☐	Is **Fit** to travel and to work in the proposed location with the following restrictions or comments:
☐	Is **Not Fit** to travel and to work in the proposed location.
☐	☐ Requires further assessment / information before risk assessment can be completed. ☐ *Request for information sent to GP* ☐ *Musculoskeletal / Fitness testing recommended* ☐ *Other testing required (see below)*

Comments

Doctors Signature:	**Date:**

Doctor / Clinic Stamp:

The examining doctor wishes to make it known that the purpose of this examination and the consequent opinions expressed are in the interests of prevention of occupational injury by the proper placement of employees in those positions best suited to their physical capabilities. This examination is not for the purpose of determining the success or otherwise of this person's application for employment.