

**Pre Travel Assessment Form**

Name……………………………. Surname………………………………. Male Female Transgender

Date of Birth……/.…/…….. Country of birth………………….. Aboriginal OR Torres Strait Islander? YES NO

STREET ADDRESS…………………………………………………. SUBURB….…………………. POSTCODE………….

EMAIL…………………………………………… **Contact details for the next 1-2 years:** HOME PHONE…………………….

WORK PHONE……………………….. MOBILE……………………………...... ETHNICITY………………………..

MEDICARE NUMBER……………………………………….. REF NUMBER…….. EXPIRY DATE……/……/……….

PENSION/HCC/DVA NUMBER………………………….. EXPIRY……/……/………

EMERGENCY CONTACT…………………………………. PHONE……………………. RELATIONSHIP…………………..

DEPARTURE DATE………/……/……….. RETURN DATE………/……/…………HOLIDAY or BUSINESS?

I will be visiting the following countries:

|  |  |  |  |
| --- | --- | --- | --- |
| **Country (in order of visit)** | **Duration (weeks)** | **Accommodation (hotel / tent / backpack)** | **Cities only** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

Please list countries you have visited previously: ……………………………………………………………………………..

Is your general health good? ............................................................... Yes No

Have you ever fainted or felt unwell soon after an injection? …….. Yes No

Could you be pregnant while away? (Females only)........................... Yes No

Does someone with lowered immunity live at home with you? Yes No

Will children be travelling with you?..................................................... Yes No

Are you allergic to eggs, medications or other substances? ............. Yes No

Please list these allergies: ..………………………………………………………………………………………………………..

Please list ALL medications you are currently taking: …………………………………………………………………………….

Please list past significant medical / health problems you have had both here and overseas. Especially note past history of

jaundice, hepatitis, deep vein thrombosis (DVT) or blood clots, ear or hearing problems or have a disease which lowers

immunity (eg cancer, HIV/AIDS, thymus disorder).

…………………………………………………………………………………………………………………………………………….

**\*\*\*NB You DO NEED to complete the following table before seeing the doctor.** PLEASE INDICATE WHICH YEAR THE FOLLOWING VACCINES WERE GIVEN. Also indicate if you have ever had any of the actual diseases measles, mumps, rubella, chicken pox. You can check with your GP or previous medical records to find this information.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccine given** | **Year** | **Vaccine given** | **Year** | **Vaccine given** | **Year** |
| Tetanus / Diphtheria /  Whooping cough(pertussis) |  | Typhoid |  | Mantoux / BCG |  |
| Polio |  | Cholera |  | Meningococcal |  |
| ‘Flu vaccine |  | Hepatitis B |  | Japanese Encephalitis |  |
| Pneumovax |  | Hepatitis A vaccine |  | Q fever |  |
| Measles / Mumps /  Rubella |  | Hepatitis A  immunoglobulin |  | Rabies |  |
| Varicella (chicken pox) |  |  |  | Yellow fever |  |



**Personal & Health Information Consent**

We respect your rights to privacy and takes our privacy obligations seriously. We comply with the Australian Privacy Principles, found under the Privacy Act 1988 (Cth). Our Privacy Policy can be obtained from:

* [www.nillmc.com.au](http://www.nillmc.com.au)
* Reception
* By calling (03) 9430 8888

We require your consent to collect personal information and health information about you. Please read this information carefully, and sign where indicated below.

Nillumbik Medical Centres collect information from you for the primary purpose of providing you healthcare services. We require you to provide us with your personal and health information such as your medical history so that we may provide our services to you.

We will also use the information you provide in the following ways:

* Appropriately manage our practice, such as conducting audits and undertaking accreditation processes, manage billings and training staff;
* Effectively communicate with third parties, including Medicare Australia, private health insurers, government departments and other practitioners involved in your healthcare.

I have read the information above and understand why my information is collected and how it is used. I acknowledge that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of care provided to me.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**PRIVACY**

Your private information is at all times treated confidentially with care and in accordance with the Australian Privacy Principles (APPs). A copy of our privacy policy is available on request.

I consent to receiving appointment reminders via SMS. YES NO

I consent to receiving Recall Reminders via SMS. YES NO

**I understand it is my responsibility to ensure all personal contact details are updated with Nillumbik and Research Medical Centre staff.**

Name/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_