Dr Kaur's Surgery

TRAVEL RISK ASSESSMENT FORM

Please complete this form **prior** to your travel appointment and return to reception

Personal details	
Name:	**Date of birth:** **Male [ ] Female [ ]**
Easiest contact telephone number- essential	
E mail	
Dates of trip	
Date of Departure	
Return date or overall length of trip	

Itinerary and purpose of visit		
Country to be visited	**Length of stay**	**Away from medical help at destination, if so, how remote?**
1.		
2.		
3.		

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 area which is	Urban		Rural		Altitude	
6. Planned activities	Safari		Adventure		Other	