Full Consult
Limited Consult
Vaccines Only
Malaria Only
Yellow Fever Only

AUCKLAND, HAMILTON, NEW PLYMOUTH, PALMERSTON NORTH, CHRISTCHURCH, NELSON

PATIENT CONSULTATION FORM

Date: …./…./….

Family Name:	**First Name:**	
Address:	**Date of Birth:**	**Male / Female**
Are you a New Zealand: Citizen ☐ Resident ☐ Tourist ☐	**NHI Number:**	
Country of Birth: NZ ☐ Other ☐ (*Please specify*)	**Ethnicity:**	
Contact email address (*please print clearly*):		
Contact Phone Number: (Home)	**(Work)**	**(Mobile)**
Occupation:	**Company Name:**	
General Practitioner (*Name and Address*)		
Next of Kin: (*Name and Contact Phone Number*)		
Payment (*Please circle*) : Personal	**Company (*Please specify*)**	

YOUR HEALTH

VACCINATIONS / IMMUNISATIONS

List any VACCINATIONS had within the last 10 years: **OR vaccine record attached ☐**

Have you had routine childhood vaccinations? **Yes ☐ No ☐**

Please describe any reactions to vaccinations:

Please list ANY allergies including:
ANY to FOOD, EGGS or MEDICINES (*Some vaccines contain eggs*)

What PRESENT or PAST Medical conditions do you have?

Please list any MEDICATIONS you are currently taking (*Include those that affect the immune system*) *or have had within the last 3 months*.

Do you currently have a temperature, or cold/'flu' symptoms? **Yes ☐ No ☐**

Females only: **Are you pregnant / contemplating pregnancy** **Yes ☐ No ☐**

Do you have a history of any of the following? (*please tick*):

Psoriasis	**Yes ☐ No ☐**	**Convulsion/Seizure/Epilepsy**	**Yes ☐ No ☐**
Hepatitis	**Yes ☐ No ☐**	**Heart rhythm problems**	**Yes ☐ No ☐**
Depression	**Yes ☐ No ☐**	**Psychiatric unwellness**	**Yes ☐ No ☐**
Cancer	**Yes ☐ No ☐**	**Blood immune disorders**	**Yes ☐ No ☐**
Blood clotting	**Yes ☐ No ☐**	**Recent surgery**	**Yes ☐ No ☐**

How did you find out about the WORLDWISE Travellers Health and Vaccination Centre? *(please tick)*

☐ Travel Agent (name) _____ ☐ G.P. (name) _____ ☐ Other – please specify _____
☐ Website ☐ Web search ☐ Article/Media/Advert
☐ White Pages/Yellow Pages ☐ Been Before ☐ Corporate organization ☐Friend

COUNTRIES TRAVELLING TO	DURATION OF TRAVEL

Departure Date: **Return Date:**

If you are having the Yellow Fever vaccine, Have you read & understood the Yellow Fever Information Handout? **Yes ☐ No ☐**

Are you traveling for: **Holiday ☐** **Business ☐**
Volunteering ☐ **Other ☐ (*Please specify*)**

Informed consent: I acknowledge that the information given above is truthful. I accept all information given will be kept confidential, and will not be released without my authority. I consent to my healthcare provider being informed of vaccinations received (NIR) in order to update applicable records. I realise that I may be given vaccinations and understand what they are for, and side effects that may be expected from them. I consent to having these vaccinations and to the reporting of any adverse events which may occur to the Centre for Adverse Reactions Monitoring (CARM). I understand there will be a $28 service fee applied to each return visit to complete a vaccination series. I understand that above information may be used for research use. In the event of non-payment of monies owing by me, WORLDWISE reserves the right to pass on to me all charges related to debt collection.

Please circle, then sign. SELF / PARENT / CAREGIVER (GUARDIAN) ***Signature:*** **……**

VACCINATION PLANNER

Disease Type	Vaccine history/notes	V1 Date……..	V2 Date……..	V3 Date……..	V4 Date……..	V5 Date……..	V6 Date……..
BCG							
Chicken Pox							
Cholera							
Hepatitis A							
Hepatitis A / B							
Hepatitis B							
Herpes Zoster							
HPV Vaccine							
Influenza							
Japanese Enceph							
Mantoux test							
Meningococcal ACYW							
Meningococcal B							
MMR							
Pneumovax							
Polio							
Q Fever							
Rabies							
Tet/Diph/Pertussis/Polio							
Tetanus / Diph							
Tetanus/Diph/Pertussis							
Typhoid Fever							
Typhoid/Hep A combo							
Yellow Fever							
Other							
Other							

Clinical Notes: *Can / cannot eat eggs* *Healthy / non-healthy*

Date	

VACCINATION RECORD

Date	Vaccine	Batch No	Expiry Date	Previous Reaction	Dose	Route	Site	RN/DR	Fee	Fee	Fee	Fee