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 $27 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							
Cholera							
Hepatitis A							
Hepatitis B							
Hepatitis A / B							
Influenza							
Japanese Enceph							
Mantoux							
Meningitis ACYW							
MMR							
Polio							
Rabies							
Tetanus / Diph							
Tetanus/Diph/Pertussis							
Tet/Diph/Pertussis/Polio							
Typhoid Fever							
Typhoid/Hep A combo							
Yellow Fever							
Other							

CONSULTATION – Checklist: patient advised on the following:

Full consultation	
Limited Pre-Travel Consultation	
Vaccines only consultation, with vaccine side-effects discussed	
Booster vaccination only	
Malaria only consultation, with medication side-effects discussed	
Yellow Fever only consultation, with vaccine side-effects discussed	

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