Full Consult
Limited Consult
Vaccines Only
Malaria Only
Yellow Fever Only

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

PATIENT CONSULTATION FORM

Date: …./…./…..

Family Name:	**First Name:**
Address:	**Date of Birth:** / **Male / Female**
Are you a New Zealand Citizen ☐ Resident ☐	**NHI Number:**

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*):

Method of Payment (*Please circle*): Visa MasterCard EFTPOS Cash Cheque AMEX accepted (*3% Surcharge*)

YOUR HEALTH

VACCINATIONS / IMMUNISATIONS
List any VACCINATIONS had within the last 10 years:

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 that you 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

Departure Date: Return Date: Duration of travel:

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

If you would NOT like to receive correspondence (*eg: test results, recalls etc*) from WORLDWISE® via email, choose one of the following:
Post ☐ Phone ☐ enter number________________________________
If you are happy with email correspondence, please note, it is your responsibility to maintain your email address details with **WORLDWISE®**

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 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 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