Community Pharmacy Malaria Risk Assessment & Supply Record

Client Name:________________________________	**Community Pharmacy:** *(stamp)*
Client Address:______________________________	
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______________________ **Post code** ___________	**Assessment undertaken by:**
☎**Tel no:**_____________________________________	**Name**__________________ **Date**________________
☎**Mobile no:**________________________________	**GP Name:**_____________________________
Email address______________________________	**Address:**_____________________________________
Date of Birth:____________________	____

Personal profile			*Travel profile*
Significant past medical history	**Y**	**N**	**Date of Departure:**________________________
			Travelling to (country + length of stay)
			1.
			2.
			3.
			Reason for travel
Current health problems	**Y**	**N**	
			Type of accommodation, rural/city
Any current medications	**Y**	**N**	
			General Comments
Allergies	**Y**	**N**	
Pregnant or planning within next 3 months?	**Y**	**N**	
Breastfeeding?	**Y**	**N**	

Is there a risk of malaria?	**Y**	**N**	*General travel health advice given* **Y** **N**
Aware/understanding of how contracted	**Y**	**N**	**Food & water** ❑ **Health insurance** ❑
Bite avoidance (nets, repellents etc)	**Y**	**N**	**Safety issues etc** ❑ **Safe sun** ❑
Signs, symptoms, diagnosis)	**Y**	**N**	**Other**
(Weight of child)__________________	**Y**	**N**	
	Y	**N**	**Notes**
Chemoprophylaxis recommended Chloroquine ❑ Proguanil ❑ Doxycycline ❑ Mefloquine ❑ Malarone ❑			

Details of chemoprophylaxis supplied

Drug(s) strength, dosage, quantity and batch number/expiry

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Supplied by: (pharmacist name) ______________________ **Signature** ________________________**Date**__________

Patient Consent

I have read and understood the patient information provided and acknowledge the advice given by the pharmacist. I confirm that the personal and travel details documented is an accurate reflection of the information provided by myself. I agree that the details I have given above in relation to presenting for this service can be recorded and used anonymously in order to evaluate and improve the service for future health care needs.

Name:______________________________ Signature: ___________________________ Date: ☐☐☐