**Antimalarials** **Haltemprice Pharmacy online** **Date: _ _ / _ _ / 2 0 _ _**

| **Patient's personal details** | |
|---|---|
| Title: Mr:▢ Miss:▢ Ms:▢ Mrs:▢ Dr:▢ | Customer Address: |
| Name: | |
| Surname: | GP Name and Address: |
| Email: | |
| Mobile: | Would you like your GP to be notified of this consultation? ▢ |
| Gender: Male:▢ Female:▢ D.O.B: _ _ / _ _ /_ _ | |

## Dates of Trip

Date of departure

Return date or overall length

## Itinerary and purpose of visit

| Country to be visited | Length of stay | Remote? Trek? Medical access? Altitude? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## Personal Medical History

| *Tick which of the following applies to you* | Yes | No | Details (to be reconfirmed at each appointment) |
|---|---|---|---|
| Do you have any recent or past medical history of note? | ▢ | ▢ | |
| Do you take any current or repeat medicines? | ▢ | ▢ | |
| Do you have any allergies to any medicines? | ▢ | ▢ | |
| Have you had a serious reaction to a vaccine, antimalarial or doxycycline before? | ▢ | ▢ | |
| Do you or any of your family suffer from epilepsy? | ▢ | ▢ | |
| Do you have a medical history of the following: anxiety, depression, heart, lung, liver, kidney, immunity, blood conditions, disorders, diabetes? | ▢ | ▢ | |

## Women only

| *Tick which of the following applies to you* | Yes | No | Details (to be reconfirmed at each appointment) |
|---|---|---|---|
| Are you pregnant or planning a pregnancy? | ▢ | ▢ | |
| Are you breastfeeding? | ▢ | ▢ | |

## Please write below any further information which may be relevant e.g. medicines, conditions...

## FOR OFFICIAL USE

### Initial consultation

| Date | Malaria Oral Medicine | Quantity | Details | Price |
|---|---|---|---|---|
| | Atovaquone + Proguanil | | | |
| | Lariam (mefloquine) | | | |
| | Doxycycline | | | |
| | Paludrine (chloroquine + proguanil) | | | |
| | Chloroquine | | | |

### Additional travel advice

| | | | | | |
|---|---|---|---|---|---|
| ▢ | Water and personal hygiene | ▢ | Travellers' diarrhoea | ▢ | Hepatitis B and HIV |
| ▢ | Insect bite prevention | ▢ | Animal bites | ▢ | Accidents |
| ▢ | Insurance | ▢ | Air travel | ▢ | Sun and heat protection |

## PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment.

Patient signature..... Date.....

Pharmacist signature..... Date.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? **Yes** / **No**

## New risk assessment form required after 5 consultations.

### For each follow-up consultation

| medicine | Qty | Details | Change in medical history? | Pharmacist Signature | Price |
|---|---|---|---|---|---|
| **No.1.** | | | ▢ Yes ▢ No | | |
| Customer Signature | | | Date | | |
| **No.2** | | | ▢ Yes ▢ No | | |
| Customer Signature | | | Date | | |
| **No.3** | | | ▢ Yes ▢ No | | |
| Customer Signature | | | Date | | |
| **No.4** | | | ▢ Yes ▢ No | | |
| Customer Signature | | | Date | | |
| **No.5** | | | ▢ Yes ▢ No | | |
| Customer Signature | | | Date | | |