Information for Family Doctor

Dear Doctor,

Thank you for seeing this volunteer, who is going on an international volunteering or gap year placement overseas - usually for 6-12 months, sometimes in countries with limited access to reliable medical facilities.

As you would imagine, overseas volunteer postings may result in increased physical and mental stress. The medical information provided in this form is used to assist the placement organization, Lattitude, find the most suitable placement for each individual. It is not a question of pass or fail, but of highlighting any areas where local support may be necessary. The volunteer will complete pages 1 to 8 prior to their appointment with you.

It would be appreciated if you could

( ) **Review pages 1-8 and and provide details**, particularly with a view to whether this issue could occur or could cause difficulties while overseas. Eg if volunteer ticks history of broken bones - please note what bones if this is healed with or without sequelae etc. If ticks headache, note if this is significant or not.

( ) Encourage all volunteers to have had **a dental check** within the last 12 months, if this is not the case.

( ) **Review all vaccines** as per records provided, and complete as necessary. We recommend all volunteers be up to date with all routine immunisations , PLUS have Hepatitis A and Influenza. Other vaccines may be recommended depending on destination.

( ) **Complete pages 8-10** of the attached medical review. Please comment on any issues that you think may be of importance, or may need special allowance made.

( ) **Ensure delegates have a plan** for management of any chronic issues eg those with a history of asthma have a written asthma management plan.

( ) **Return entire form to the volunteer** who will forward to Latitude Global Volunteering.

Thank you for your assistance. Please email or call with any queries.
Yours faithfully,

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contact@drdeb.com.au

Dr DEB'S TRAVEL MEDICINE CENTRES WITH YOU EVERYWHERE
THE TRAVEL DOCTOR

SCREENING QUESTIONNAIRE

Office use only

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VOLUNTEER TO READ AND COMPLETE PLEASE

The primary purpose of this questionnaire is not to pass or fail. It is to anticipate any potential medical issues which may occur so that appropriate measures may be taken to lower your risk and increase your chance of a successful placement. A summary of this information may be required by placement organiser or the agency responsible for your medical care while overseas. No information will be sent without your signed consent for release, which follows at the end. You can withdraw consent at any time in writing. **It is most important that you, the volunteer, complete this form yourself.**

Your Details (PLEASE USE BLOCK LETTERS/PRINT NEATLY)

First Name | Last Name

Date of Birth | M/F | Start date of placement

Placement country and region if known | Estimated length of placement

Home Address

Phone (daytime) | Email Address

Overseas Position Involves

Brief description of duties overseas .....

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.....

Cardiovascular (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING) (TICK MORE THAN ONE BOX IF REQUIRED)

- ☐ palpitations
- ☐ high blood pressure
- ☐ raised cholesterol
- ☐ ankle swelling
- ☐ chest pain
- ☐ anaemia
- ☐ other (specify).....
- ☐ heart attack
- ☐ valve problem
- ☐ heart surgery
- ☐ DVT (thrombosis)
- ☐ heart murmur
- ☐ NONE OF THESE.....

Details: (Doctor please add details)

Respiratory (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING) (TICK MORE THAN ONE BOX IF REQUIRED)

- ☐ asthma
- ☐ emphysema
- ☐ tuberculosis
- ☐ shortness of breath
- ☐ pneumonia
- ☐ collapsed lung/pneumothorax
- ☐ other (specify).....
- ☐ pleurisy
- ☐ bronchiectatis/bronchitis
- ☐ coughing blood
- ☐ tendency to chest infections
- ☐ pulmonary embolism
- ☐ NONE OF THESE.....

Details:

if yes to Asthma
What age were you first diagnosed with asthma? .....

How many days off work or school have you had due to asthma in the last 2 years?.....

Are there any known triggers for your asthma? If yes, please list:

.....

Your Name (full name)

Gastrointestinal (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ stomach ulcer
- ☐ gall stones
- ☐ unexplained weight loss
- ☐ hepatitis/jaundice
- ☐ haemorrhoids/piles
- ☐ indigestion
- ☐ abdominal pain
- ☐ irritable bowel syndrome
- ☐ hiatus hernia
- ☐ other (specify).....
- ☐ blood in motions
- ☐ frequent nausea, vomiting/vomit blood
- ☐ endoscopy
- ☐ colonoscopy
- ☐ ulcerative colitis/ crohn's disease
- ☐ pancreatitis

NONE OF THESE..... ☐

Details: (Doctor lease add details)

Neurological/Psychological (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ depression
- ☐ anxiety/phobias/compulsions
- ☐ counselling
- ☐ panic attacks
- ☐ epilepsy/fits
- ☐ headaches/migraine
- ☐ deafness
- ☐ insomnia
- ☐ other (specify).....
- ☐ fainting
- ☐ paralysis/stroke
- ☐ referred to or seen a psychiatrist/psychologist
- ☐ head injury/concussion
- ☐ tingling/numbness/pain
- ☐ post traumatic stress disorder

NONE OF THESE..... ☐

Details:

Psychological

During the past month:

Have you felt feeling down, depressed or hopeless? y n

Have you felt little interest or pleasure doing things? y n

What percentage of the time do you expect this placements will be fun .....%

What is the primary reason for undertaking this placement?

.....

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.....

.....

Overseas placement etc

Overseas placement can be demanding and problems with adjustment to culture, travel, separation from family etc can sometimes occur. Do you have any partical concerns regarding your ability to adjust to these demands? y n

Comments .....

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.....

Details:

Musculoskeletal (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ arthritis
- ☐ broken bones/sprains
- ☐ muscle weakness
- ☐ repetitive strain injury (RSI)
- ☐ other (specify).....
- ☐ back or neck pain
- ☐ joint surgery

NONE OF THESE..... ☐

Details:

Your Name (full name)

Skin (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ psoriasis
- ☐ skin cancers
- ☐ herpes
- ☐ eczema/dermatitis
- ☐ other skin problems (specify)
- ☐ wounds failing to heal
- ☐ recurrent boils
- **NONE OF THESE** ☐

When outdoors, how often do you do the following?	Always	Sometimes	Rarely
Wear a hat			
Wear sunglasses			
Apply sunscreen before hand			
Wear protective clothing			

Details:

Genito-urinary (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ chlamydia
- ☐ kidney stones
- ☐ bladder problems
- ☐ blood in the urine
- ☐ urinary tract infection
- ☐ other kidney or urinary problems (specify).....
- ☐ sexually transmitted diseases
- ☐ lose urine when cough or laugh
- **NONE OF THESE** ☐

Details:

Men only (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ testicular problems
- ☐ prostate problems
- ☐ hernia
- ☐ other (specify).....
- ☐ significant change in urinary flow
- **NONE OF THESE** ☐

Details:

Women only (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ irregular periods
- ☐ heavy periods
- ☐ periods stopped
- ☐ other gynaecological problem.....
- ☐ breast lumps
- ☐ prone to vaginal thrush
- ☐ pregnant or planning
- **NONE OF THESE** ☐

Details:

Other (PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING)

- ☐ diabetes – on insulin (_)
  – on tablets (_)
  – diet controlled (_)
- ☐ immune weakness
- ☐ cancer of any sort
- ☐ thyroid problem
- ☐ chronic fatigue
- ☐ clotting problems
- ☐ Thrombosis or DVT
- **NONE OF THESE** ☐

Details:

Glasses

Do you wear glasses? y n

Do you wear contact lenses? y n

Is your last optometrist or eye specialist review over 12 months ago? y n

Details:

Dental

Have you seen the dentist in the last 12 month? y n

If your last dental check was more than 12 months ago, you are strongly encouraged to have a checkup prior to departure. Dental abcesses are very painful and emergency dental treatment while overseas is inconvenient, expensive and not always safe.

Details:

Your Name (full name)

Diet

Are you currently following, or planning to start, a special type of diet or a restricted diet? y n

If yes

Vegetarian y n

No Red Meat y n

Other (please describe).....

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Details:

Weight

Do you feel your current weight is about right for you? y n

Do you often think about your weight and or body size? y n

Have you ever been told you have an eating disorder (anorexia, bulimia)? y n

Details:

Exercise

Please tick which type of exercise do you do in a typical week?

- ☐ No regular exercise
- ☐ Jogging
- ☐ Brisk walking
- ☐ Gymnasium workout
- ☐ Other (state) .....

Average session is ☐ minutes ☐ times per week

Details:

EPWORTH SLEEPINESS SCALE (Please circle)

Scale: 0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Being a passenger in a motor vehicle for an hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Stopped for a few minutes in traffic while driving	0	1	2	3

TOTAL SCORE:

EPWORTH SCORE

Score	Rating
0 – 9	Normal
> 10	Need sleep review

Smoking

Have you ever smoked tobacco y n

If yes which best describes your smoking history

- ☐ Never smoked regularly
- ☐ Current: average ☐ cigs per day from age ☐ yr

Details:

Alcohol & Recreational Drugs

Please estimate your average weekly alcohol consumption in standard units.

1 unit = 30ml measure of spirits 120ml glass of wine
285ml glass of beer 60ml glass of sherry

Estimates total units per average week ☐ units.

How many alcohol free days do you have per week ☐ d.

How often do you have six or more drinks on one occasion?

☐ Never ☐ Monthly or less
☐ Weekly ☐ Daily or almost daily

In the last 12 months have you used Marihuana or other recreational drugs? y n

Details:

Medications

Do you take any medications? y n

If yes, please list any prescription and non-prescription medication which you use regularly or as required. Include inhalers, patches, laxatives, fluid tablets, weightloss medication, prescription creams, vitamins and 'quit smoking' medication.

Name Dose

.....

.....

.....

.....

.....

Details:

Allergies

(Tick more than one if applicable)

Do you have any known allergies? y n

☐ I get hayfever/eczema/asthma

☐ I am allergic to.....

☐ I have a serious or life threatening allergy to

.....

☐ I have previously required adrenaline (Epinephrine/Epipen) or hospitalisation for an allergic reaction

☐ I carry adrenaline (eg Epipen) when travelling

Details:

Illness/Injuries/Surgery

Have you ever had surgery to remove any body parts? y n

If yes please tick:

☐ tonsils ☐ appendix ☐ spleen ☐ breast

☐ other (please name) .....

Have you been absent from school in the last 5 years for more then a week due to illness, injury or a surgical operation? y n

If yes please outline.....

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.....

Have you been referred to a specialist in the last 5 years? y n

If yes please outline.....

.....

YOU WILL NEED TO ATTACH A REPORT FROM YOUR SPECIALIST/TREATING PRACTITIONER OR YOUR MEDICAL CANNOT BE PROCESSED.

Details:

Your Name (full name)

Screening Tests

Have you had a skin cancer check? y n

Details:

If Yes when: m yr

☐ Normal

☐ Abnormal (please state).....

Have you had a test for HIV AIDS in the last 5 years? y n

If yes: Result .....

Vaccine History

Vaccine Record: Please complete as much as possible, with name of vaccine and date attach Vaccine records .

Vaccine for Disease	Date	Date	Date	Date	Date	Date
Polio						
Tetanus Diphtheria Pertussis						
Haemophillus Influenzae B						
Measles, Mumps Rubella						
Varicella (Chicken pox)						
HPV (Gardasil)						
Meningitis						
Hepatitis B						
Hepatitis A						
Influenza						

Your Name (full name)

Family History

Do you have a parent or sibling with any of the following?

- ☐ Male heart disease below age 55
- ☐ Female heart disease below age 65
- ☐ DVT/Thrombosis/Lung embolism
- ☐ Stroke
- ☐ Bowel Cancer
- ☐ Breast Cancer
- ☐ Diabetes
- ☐ Schizophrenia/Mania/Depression
- ☐ Alcohol problem
- ☐ Other health problems that run in the family

Comments.....

.....

.....

.....

.....None of the above ☐

Details:

Other Concerns

Do you have concerns regarding any problems we have not asked about or other health issues which might occur while you are away? (If so, the doctor will discuss these with you). y n

If Yes (please state).....

.....

.....

.....

.....

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Details:

THANK YOU

WE WILL USUALLY NEED TO SEE A REPORT FROM ANY SPECIALIST YOU HAVE SEEN WITHIN THE PREVIOUS 5 YEARS.

Please ensure your name is completed at the top of each page.

HONESTY – PLEASE READ THIS CAREFULLY

If you know you have not included something you find difficult, or you think might be considered unacceptable, please consider the following carefully.
Anything you have omitted could be the issue with the potential to cause you difficulty in a stressful assignment in the field. Remember being honest about your medical status boosts your capacity to perform well in the field. It helps your placement organisation provide the right posting and support network. It protects your colleagues from extra burdens. It safeguards the quality of the work you can deliver. Ultimately it helps the people you are going to serve.

AUTHORITY TO RELEASE RESULTS

I understand the importance of being honest in my responses on this form and I have completed the above information correctly to the best of my knowledge and recollection. I understand this medical assessment is for the purpose of identifying potential health problems during my placement. I authorise the examining doctor to release this report in part or in full, by confidential fax, email or post, together with relevant pathology results or reports if required to: Lattitude Global Volunteering and potential host organisations and its nominated medical advisors: Dr Deb the Travel Doctor.

Signature

/ /20

Witness

/ /20

PHYSICAL EXAMINATION

Name

Date of Birth ☐ M ☐ F

Date of Medical

DD98 c

Proof of identity produced? y n ☐ Passport ☐ Drivers Licence ☐ Other Number:.....

Body Habitus

Doctor's Notes:

Height cm Weight kg

Body Mass Index kg/m²

Person with raised BMI are at increased risk of difficulties with mobility and may have increased risk of injury. They may need assistance with dietary issues. I strongly recommend influenza vaccine for all candidates over BMI 30 due to increased risk of hospitalisation from influenza.

Are there any operation scars? y n

Are there any abnormal skin lesions? (eg dysplastic naevi etc) y n

Are there any identifying marks (tatoos/scars)? y n

Facial hair? y n

Is there any lymphadenopathy? y n

Waist circumference cm

Narrowest point between ribs and hips when viewed from front after exhaling.

Hip circumference cm

Point where buttocks extend the maximum.

Waist-Hip Ratio

Waist-hip ratio is a strong predictor of cardiovascular disease. Increasing death rates appear women >0.8 and men >0.9.

Cardiovascular System

Doctor's Notes:

Blood pressure readings
If over 140/90 please provide 2 further readings at 5 minute intervals.

Resting	1	2	3
Systolic			
Diastolic			

Pulse rate

per minute

Are there any varicose veins? y n

Is there any abnormality of the pulse? y n

Is there any abnormality of the heart sounds? y n

Is there a heart murmur? y n

Respiratory System

Doctor's Notes:

Is the trachea displaced? y n

Are the breath sounds abnormal? y n

Are there any added sounds? y n

Is spirometry abnormal? (asthma, smoker or other indication) nd y n

Alimentary System

Doctor's Notes:

Are there any abnormalities of the teeth, gums or oropharynx? y n

Is there any abnormal tenderness or organomegaly? y n

Other abnormality? (please specify).....

Urine Analysis

Doctor's Notes:

Blood [ ] Glucose [ ] Protein [ ]

(We strongly encourage all volunteers to have a urine 'dip' test)

Central Nervous System

Doctor's Notes:

Are there any abnormalities of the auditory canals or ear drums? y n

Are the pupils abnormal? y n

Is there any abnormality in: tone, power, co-ordination, sensation? y n

Are the reflexes abnormal? y n

Are there any tremors? y n

Is there any evidence of colour blindness? y n

Visual acuity (without correction) R 6/ L 6/

(with correction) R 6/ L 6/

Is hearing normal in both ears? y n
(Renne/Weber test with tuning fork is sufficient)

Musculo-Skeletal

Doctor's Notes:

Is there a limp or abnormality of gait? y n

Is there any restriction of movement or pain in neck, back or limb joints? y n

Is there any evidence of joint surgery? y n

Would the applicant have any difficulty running? y n

Would the applicant have any difficulty squatting? y n

Would the applicant have any difficulty climbing stairs? y n

Would the applicant have any difficulty climbing ladders? y n

Straight leg raising L [ ] R [ ] in degrees

Further Tests and Investigations

Doctor's Notes:

Are any further investigations required? y n

Is medical specialist opinion required? y n

Would you recommend a dental opinion? y n

Are specialist/counsellor etc reports attached? y n

Name (full name)

Other

In your opinion are there any medical conditions that will need ongoing management over the next twelve months.

Condition	Routine Management
eg: Asthma	Regular Ventolin

Are there any other special needs or medical requirements that this volunteer may require during their placement if a known condition was to deteriorate.

Condition	Recommended Management
eg. Asthma	Attack requiring Prednisone 50mg daily for 3days

Name of Medical Examiner

Checklist before sending ( ) Doctors notes re any positive history
( ) All sections complete ( ) Specialist reports attached if any

Doctors Signature

Date of Medical Examination

CLINIC DETAILS or STAMP

Clinic Name:.....

Address:.....

Phone:.....

Email:.....