Travel Risk Assessment form

Travel Risk Assessment	Pre-arrival to Vejthani Hospital	
	Yes	No
Cardiovascular Problems		
1. Unstable angina?		
2. Uncontrolled cardiac arrhythmia?		
3. Coronary artery bypasses graft within 10 days?		
4. Decompensated congestive cardiac failure?		
5. Severe symptomatic valvular heart disease?		
6. Uncontrolled hypertension?		
7. Complicated myocardial infarction within 4-6 weeks?		
8. Uncomplicated percutaneous coronary interventions (e.g. angioplasty with Stent Placement) within 5 days?		
9. Cerebrovascular accident within 3 days?		
10. Uncomplicated myocardial infraction within 7 days?		
Infection		
1.Do you have any of these following symptoms?		
- Fever		
- Cough		
- Rash		
- Runny nose		
- Sore throat		
- Headache		
- The nose does not smell		
- decreased taste buds		
- Diarrhea		
- Difficulty breathing		
- Nausea and vomiting		
- Muscle aches		
- Tired		
2.Have you has any past medical history of drug-resistant infection?		
3.Have you contacted closely with anyone with those symptoms or tuberculosis		

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	Yes	No
or diphtheria or any other diseases?		
Deep Vein Thrombosis		
1. Major surgery or hip / knee joint replacement surgery in last 12 weeks?		
2. Prior deep vein thrombosis or pulmonary embolism?		
3. Bedridden, Paralysis or cast of lower extremity?		
4. Tenderness or swelling of leg?		
5. Cancer treatment within last 6 months or current palliation?		
Chronic disease and threat		
1. Diabetes mellitus (If a blood glucose test (HbA1C, DTX) is attached)		
2. Chronic obstructive bronchial disease (If available, attach chest x-ray results)		
3.Chronic kidney disease		
4. Obesity (BMI> 40)		
5. Receive an organ transplant.		
6.Have passed 36 weeks of pregnancy (or 32 weeks if you are carrying twins, triplets, etc.).		
7.Children with congenital heart failure		

I have read and understood the text in detail and confirm that all information recorded above is true. Along with understanding of disease or complications which may have exacerbated this increases the length of hospital stay and increases the cost of hospitalization. Please sign or put fingerprints below.

If patient is unable to sign	Signature..... ○Patient (.....) Date.....Time……
	Signature..... ○ Legal Representative (.....) Date..... Time……....
Fingerprint ..... Of Patient/ Legal Representative Side: ○Right ○ Left Date..... Time.....	Signature.....Witness (.....) Date.....Time.....