Travel Medicine and Vaccinations Pre-Travel Consultation Form

Prior To Your Visit

Thank you for your interest in our Travel Consultation Services.

Our pharmacists are trained to provide a full consultation, including an assessment of your health and instructions on how to minimize the risk of travel so you can enjoy your trip fully. We also have the ability to prescribe and administer vaccinations, and prescribe travel-related medications specific to this trip. This may include medications related to malaria prophylaxis, diarrhea prophylaxis and treatment, post-antibiotic yeast infection risk, altitude sickness prevention and treatment, motion sickness, and sleep aids. We will include both verbal and written information on preventative care. You will be given a choice to have any prescriptions filled during your clinic visit at one of our pharmacies, or we can phone-in prescriptions to a pharmacy of your choice.

We can provide this service to patients 12 years of age and above, without known immunocompromising conditions, and without high risk for anaphylaxis for vaccine administration prior to travel. If you are requesting yellow fever vaccination, or any evaluation of vaccinations required for travel, you must schedule and attend a full consultation service.

In order to provide you the best service, we do have a few requirements. You may be charged a fee for this service, due at the time of appointment scheduling, and you may be subject to a cancellation fee if you cancel within 72 hours prior to your appointment. Each travel companion is subject to their own consultation appointment and fee. You agree to fill out the Pre-Travel Consultation Form and provide this to the pharmacy at least 1 week prior to your appointment in order to allow time to provide you the best information available and ensure all vaccinations required are in stock at the time of the appointment. You must allow time for a full consultation, up to 30 minutes, and an additional 15 minutes after any vaccination administration to monitor for signs of severe allergic reaction. You must agree to see your primary care physician and discuss your travel if you have an infection occurring days to months upon your return.

If you are determined to need to see a specialist practitioner for your consult, after the pharmacist initial evaluation of the Pre-Travel Consultation form and prior to your visit, the pharmacy will inform you as soon as possible and you will be refunded the consultation fee.

I, ______________________________, have read, fully understand, and agree to the above terms prior to consultation.

______________________________ ______________________

Signature of Patient Receiving Consultation, or Legal Guardian Date

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PLEASE PROVIDE TO THE PHARMACY AT LEAST ONE WEEK PRIOR TO YOUR SCHEDULED APPOINTMENT.

Name:	**Phone:**	**Date:**
Address:	**Email:**	

Country of Birth:	**Occupation:**	☐ **M** ☐ **F**	**D.O.B.**	**Age:**

Personal Physician name:	**Physician Phone:**
Physician Address:	

Have you previously traveled out of the United States? ☐ **No** ☐ **Yes (Please list locations)**

Are you traveling alone? ☐ **Yes** ☐ **No**	**If no, list who you are traveling with and ages:**
Departure date:	**Return date:**

Please list in order all countries AND cities you plan to visit, including LAYOVERS, and the length of stay

1.	**3.**
2.	**4.**

TRIP PURPOSE: check all that apply

- ☐ **Business**
- ☐ **Pleasure**
- ☐ **Study**
- ☐ **Volunteer or humanitarian work**

PREPARATION NEEDS

- ☐ **Passport/Visa Information**
- ☐ **Medical Form Completion Needed**
- ☐ **Overseas Medical Insurance Information**
- ☐ **Medical Evacuation Insurance Information**

ACCOMODATIONS: check all that apply

- ☐ **Hotel 4 or 5 Star**
- ☐ **Hotel 2 or 3 Star**
- ☐ **Hostel**
- ☐ **Private home**
- ☐ **Camping**
- ☐ **Safari**
- ☐ **Staying with locals**
- ☐ **Long-stay apartment**
- ☐ **Cruise ship**

TRIP ACTIVITIES: check all that apply

- ☐ **Public transportation e.g. bus, train**
- ☐ **Biking**
- ☐ **Rental car**
- ☐ **Water sports e.g. swimming, boating**
- ☐ **Climbing or Hiking**
- ☐ **Ascending to altitudes >7000ft / 2300m**
- ☐ **Visiting schools, hospitals, orphanages**
- ☐ **Health care worker**
- ☐ **Contact with animals**
- ☐ **Safari**
- ☐ **Cruise**

ALLERGIES

Medication allergy ☐ **No** ☐ **Yes Which ones?**

Vaccine allergy? ☐ **No** ☐ **Yes Which ones?**

Food allergy? ☐ **No** ☐ **Yes Which ones?**

Environmental allergies e.g. hayfever, bee stings? ☐ **No** ☐ **Yes Which ones?**

WOMEN ONLY		
When was your last period?	Are you pregnant? ☐ No ☐ Yes, Due _____	Breastfeeding ☐ Yes ☐ No
Are you at risk for pregnancy? ☐ Yes ☐ No	What is your method of birth control?	

IMMUNIZATION HISTORY

Do you have a written record of your vaccinations? ☐ Yes ☐ No				
Have you had any serious reactions to any vaccines? ☐ Yes ☐ No				
Vaccines	**Date(s) Received**	**Never had**	**Not sure**	**Had disease**
Tetanus-Diphtheria (Td or Tdap)				
Measles, Mumps, Rubella (2 doses)				
Polio, childhood series and adult booster				
Shingles (Zostavax or Shingrix)				
Chicken pox (Varicella) (2 doses)				
Meningitis (Menomune or Menactra)				
Pneumonia (Pneumovax23 or Prevnar13)				
Influenza (flu)				
Hepatitis A (2 doses)				
Hepatitis B (3 doses)				
Typhoid (☐ oral or ☐ injectable)				
Yellow Fever				
Japanese Encephalitis (2 doses)				
Rabies (3 doses)				
Other vaccines:				

MEDICAL HISTORY

Psychiatric problems ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Gastrointestinal problems ☐ Yes ☐ No
Irregular heartbeat ☐ Yes ☐ No	Heart disease or surgery ☐ Yes ☐ No	Respiratory problems ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No	Immunity problems ☐ Yes ☐ No	Immune suppression drugs ☐ Yes ☐ No

List Others: G6PD Deficiency, Blood Disorders, Diabetes, Ear/Eye Issues, Gout, Kidney or Liver Disorders, Ulcers, Urinary Disorders, etc.

Please explain any "yes" answers:

Have you had any surgeries? ☐ Yes ☐ No What kind?

PLEASE LIST ALL YOUR CURRENT MEDICATIONS (Include prescriptions, over-the-counter, supplements and eye drops)			
Name of medication	**Condition or reason for use**	**Name of medication**	**Condition or reason for use**
1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

Please list additional questions or concerns that you might have regarding your travel (international voltage requirements, currency exchange, dealing with seasickness, etc.)

The above information is complete and accurate to the best of my knowledge. I hereby consent to consultation and treatment / administration of vaccines by the provider. I understand that payment in full is due when services are rendered. A portion of these charges may be reimbursable by insurance.

____ ____________________

Signature of Patient Receiving Consultation, or Legal Guardian **Date**

____

Printed Name, If Different From Traveler