



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, influenza treatment, diarrhea prophylaxis and treatment, post-antibiotic yeast infection risk, altitude sickness prevention and treatment, and motion sickness. We will include both verbal and written information on preventative care. You may fill prescriptions at a pharmacy of your choice.

We can provide this service to patients 12 years of age and above, without high risk for anaphylaxis for any needed 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. Abbreviated consultations for persons who have had a full consult with us previously and are traveling to the same/similar area may be available.

In order to provide you the best service, we do have a few requirements. You have received a copy of our privacy practices and clinic policy. You consent to treatment and billing of services, and understand we may need to share your visit information with partnering prescribers and/or your health insurance plan for quality assurance and billing purposes. 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. 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. However, if a full evaluation has been started and referral is recommended in addition to your visit with us, no refunds are available. 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. If you need travel or health-related forms to be completed during your visit, you will bring these with you to the visit. 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 understand that prevention is not a guarantee of freedom from ailment, and you agree to see a primary care provider and discuss your travel if you have an infection occurring days to months upon your return.

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 COMPLETE AND RETURN FORM AT LEAST ONE WEEK PRIOR TO YOUR SCHEDULED APPOINTMENT			
Name:		Date of Birth:	Today's Date:
Preferred Name, if different:			
Address:		Email:	
Phone:	Occupation:	Gender:	Gender Assigned at Birth:
Country of Birth:		Ethnicity and Race:	
Primary Care Provider Name, Phone, and Address:			
Have you previously traveled out of the United States? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please list locations)			
Are you traveling alone? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please list who you are traveling with, and if they are a minor)			
Departure date:		Return date:	
Please list in order all countries AND cities you plan to visit, including LAYOVERS, and the length of stay			
1.		4.	
2.		5.	
3.		6.	
TRIP PURPOSE: check all that apply		ACCOMODATIONS: check all that apply	
<input type="checkbox"/> Business <input type="checkbox"/> Pleasure <input type="checkbox"/> Study <input type="checkbox"/> Volunteer or humanitarian work		<input type="checkbox"/> Hotel 4 or 5 Star <input type="checkbox"/> Hotel 2 or 3 Star <input type="checkbox"/> Hostel <input type="checkbox"/> Private home <input type="checkbox"/> Camping <input type="checkbox"/> Safari <input type="checkbox"/> Staying with locals <input type="checkbox"/> Long-stay apartment <input type="checkbox"/> Cruise ship	
PREPARATION NEEDS		TRIP ACTIVITIES: check all that apply	
<input type="checkbox"/> Passport/Visa Information <input type="checkbox"/> Medical Form Completion Needed <input type="checkbox"/> Overseas Medical Insurance Information <input type="checkbox"/> Medical Evacuation Insurance Information		<input type="checkbox"/> Public transportation e.g. bus, train <input type="checkbox"/> Biking <input type="checkbox"/> Rental car <input type="checkbox"/> Water sports e.g. swimming, boating, scuba <input type="checkbox"/> Climbing or Hiking <input type="checkbox"/> Ascending to altitudes >7000ft / 2300m <input type="checkbox"/> Visiting schools, hospitals, orphanages <input type="checkbox"/> Health care worker <input type="checkbox"/> Contact with animals <input type="checkbox"/> Safari <input type="checkbox"/> Cruise	



ALLERGIES			
Medication, vaccine, food, or environmental allergy <input type="checkbox"/> No <input type="checkbox"/> Yes Which ones?			
WOMEN ONLY			
When was your last period?	Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, Due _____	Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you at risk for pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		What is your method of birth control?	
IMMUNIZATION HISTORY			
Do you have a written record of your vaccinations? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, you may attach a copy instead of the boxes below			
Have you had any serious reactions to any vaccines? <input type="checkbox"/> Yes <input type="checkbox"/> No Reaction?			
Vaccines	Type and Date(s)	Did not receive, or uncertain	Had disease
Tetanus-Diphtheria (Td or Tdap)			
Measles, Mumps, Rubella			
Polio, childhood series and adult booster			
Shingles (Zostavax or Shingrix)			
Chicken pox (Varicella)			
Meningitis (Menomune or Menactra)			
Pneumonia (Pneumovax23 or Prevnar13)			
Influenza (flu)			
Hepatitis A			
Hepatitis B			
COVID-19			
Typhoid (<input type="checkbox"/> oral or <input type="checkbox"/> injectable)			
Yellow Fever			
Japanese Encephalitis			
Rabies			
Other vaccines:			
MEDICAL HISTORY			
Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal problems <input type="checkbox"/> Yes <input type="checkbox"/> No	
Irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory problems <input type="checkbox"/> Yes <input type="checkbox"/> No	
Psoriasis <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunity problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune suppression drugs <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind?			



PLEASE LIST ALL YOUR CURRENT MEDICATIONS (Include prescriptions, over-the-counter, supplements and eye drops)			
Name of medication	Reason for use	Name of medication	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, sexual health and sexually transmitted disease and HIV prevention, 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.

****PLEASE ATTACH A COPY OF THE FRONT/BACK OF YOUR MEDICAL AND PHARMACY HEALTH INSURANCE CARDS****

Signature of Patient Receiving Consultation, or Legal Guardian

Date

Printed Name, If Different From Traveler