Travel Medicine

All information requested is necessary
This form is kept confidential in our office and is not released to anyone.

HEALTHY TRAVELER

Information

PLEASE PRINT CLEARLY **Today's Date** _____/_____/_____

CHECK ONE: I am a NEW patient ___ I am a RETURNING PATIENT ___ When was your last visit? ___/___/___

LAST Name _____ **FIRST** Name _____ **MIDDLE** Name _____

STREET Address _____ **Birthdate:** Month _____ Day_____ Year _____

City _____ State _____ Zip Code _____ Male ___ Female____ Age Today _____

Mobile/Cellular _____/_____ Accept Text Messages? Yes___ No___ Home/Office _____/_____

Your email address: _____ Last 4 Digits of your Social Security _____

Status: Single __ Married __ Minor under 18 ___ Employer _____ Occupation_____

REQUIRED: Emergency Contact Name _____ Phone_____/_____ Relationship _____

Under 18 years old, your parent or legal guardian is _____ Telephone _____/_____

HELP US: How did you learn about our clinic? _____

I DECLINE full travel consultation and request only the following _____Your Initials Here _____

Travel Itinerary

Purpose of this travel: Vacation ___ Business ___ Volunteer/Missionary ___ Relocation ___ Other _____

FIRST Country of Visit: _____ **Arrival Date** ____/____/____ **How Many Days?** _____
City/Area of Country (1) _____ Number of Days_____ (2) _____ Number of Days_____
(3) _____ Number of Days_____ (4) _____ Number of Days_____

SECOND Country of Visit: _____ **Arrival Date** ____/____/____ **How Many Days?** _____
City/Area of Country (1) _____ Number of Days_____ (2) _____ Number of Days_____
(3) _____ Number of Days_____ (4) _____ Number of Days_____

THIRD Country of Visit: _____ **Arrival Date** ____/____/____ **How Many Days?** _____
City/Area of Country (1) _____ Number of Days_____ (2) _____ Number of Days_____
(3) _____ Number of Days_____ (4) _____ Number of Days_____

FOURTH Country of Visit: _____ **Arrival Date** ____/____/____ **How Many Days?** _____
City/Area of Country (1) _____ Number of Days_____ (2) _____ Number of Days_____
(3) _____ Number of Days_____ (4) _____ Number of Days_____

FIFTH Country of Visit: _____ **Arrival Date** ____/____/____ **How Many Days?** _____
City/Area of Country (1) _____ Number of Days_____ (2) _____ Number of Days_____
(3) _____ Number of Days_____ (4) _____ Number of Days_____

SIXTH Country of Visit: _____ **Arrival Date** ____/____/____ **How Many Days?** _____
City/Area of Country (1) _____ Number of Days_____ (2) _____ Number of Days_____

Medical History

• IMMUNIZATION HISTORY

1. Have you ever had a bad reaction or side effect from a vaccination? If yes, explain YES ___ No ___

2. Have you ever fainted from an injection? YES ___ No ___

3. In the past **30 DAYS,** have you had any of the following vaccinations? **Chickenpox** (Varicella), **Yellow Fever**, **MMR** (measles/ mumps/rubella) or **Flu** (Nasal Flu only)? YES ___ No ___

• MEDICATIONS

6. Are you now taking any of the following medicines?
   - meds that affect the immune system? YES ___ No ___
   - steroids, prednisone, or cortisone (tablets or injection)? YES ___ No ___
   - rheumatoid meds such as Humira, Remicade, etc.? YES ___ No ___
   - cardiac (heart) meds? YES ___ No ___
   - blood thinners? YES ___ No ___
   - antibiotics? YES ___ No ___

7. Please list **RX PRESCRIPTION and Over The Counter MEDICINES** you now are taking (NO NEED to list dosage or how often you take them)

IF NONE, CHECK HERE _____

a. _____ b. _____ c. _____

d. _____ e. _____ f. _____

g. _____ h. _____ i. _____

• YOUR GENERAL MEDICAL CONDITION

Do you have a fever or acute illness today? YES ___ No ___

(Female patient) Could you now be pregnant or might you become pregnant in the next 30 days? YES ___ No ___

Do you have chronic health problems with heart, lung, kidney, no spleen, complement deficiency, or long term aspirin use? If yes, explain _____ YES ___ No ___

Do you have an immunocompromised condition such as HIV/AIDS, leukemia, cancer, Multiple Sclerosis, Rheumatoid arthritis, etc? If yes, explain _____ YES ___ No ___

Do you have blood coagulation disorder, severely low platelet count or serious bleeding? YES ___ No ___

Have you ever had an organ transplant? _____ YES ___ No ___

Have you had your thymus gland removed or thymus gland problems such as myasthenia gravis, Di George syndrome or thymoma? YES ___ No ___

• YOUR ALLERGIES

Do you have any drug allergies? YES ___ No ___

Do you have allergies to antibiotics such as Sulfa, Azithromycin, Erythromycin, Doxycycline, Neomycin (including streptomycin, polymixin, gentamicin), Amphotericin B? YES ___ No ___

Any allergies to vaccine or its components (latex, gelatin, yeast)? YES ___ No ___

Your Consent and Understanding

PLEASE REVIEW: INITIALS AND SIGNATURE REQUIRED

I am requesting Healthy Traveler Clinic® to review my completed travel medicine registration and upon completion of review, make recommendations for appropriate vaccinations for this particular trip and prescribe oral medications as needed.

After the completed review, I can return to Healthy Traveler Clinic® during normal clinic hours and request the recommended vaccinations be administered to me as well as dispensed any oral medications. Cost of vaccination(s) and other oral medication(s) will be at additional costs in addition to my travel medicine review fee.

If later you decide to have Healthy Traveler Clinic® administer all your vaccinations and/or oral medications dispense, YOU MUST RETURN WITHIN THIRTY (30) DAYS FROM DATE OF SIGNATURE BELOW. This review is only valid for thirty (30) days.

INITIALS HERE _____

YOUR VACCINATION AND ORAL MEDICINE SIDE-EFFECTS

Most modern vaccines have few side-effects. Depending upon the vaccine type, you may have some redness, tenderness or swelling where an immunization was given. Occasionally a slight fever may occur which is usually gone in a few hours. You may want to take some acetaminophen (Tylenol) for this. As with any food or medicine, there is a small risk of an allergic reaction which could be mild or even life-threatening.

Most medications can have some side-effects. In looking at your medical history and health risks during travel, we endeavor to select drugs that prevent or minimize these. We offer medicines for traveler's diarrhea, motion sickness, altitude sickness as well as several types of malaria medications and others. The physician will be happy to discuss possible adverse reactions with you. Package "inserts" are available for all medicines and vaccines for you to read should you desire.

INITIALS HERE _____

YOUR MALARIA MEDICATION

You will be counseled by our physician as to the appropriate malaria medication based on your itinerary and current medical standards. You will also be instructed as to how and when to take it and any side effects that may be applicable to your own specific health. Note that prevention of malaria includes medication, use of insect repellents, proper clothing, travel adjustment and your own common sense.

INITIALS HERE _____

INSURANCE BILLING FOR TRAVEL IMMUNIZATIONS AND VACCINATIONS

We are not a member of any insurance network or plans, therefore, we are unable to provide insurance billings on your behalf. We will provide you with a statement of all services rendered during your visit. Statements are provided only to actual person(s) visiting our office for consultation. If you wish to file an insurance claim, this will be your responsibility. Be aware that travel-related services are not always covered by employer paid insurance plans. If you need additional assistance in bill submission, we may be able to provide it if time permits but we do reserve the right to charge for extra time involved.

INITIALS HERE _____

MEDICARE WAIVER OF LIABILITY and INFLATION REDUCTION ACT (IRA) AGES 64+

In the case you are a Medicare Recipient, Medicare is likely to deny payment for travel immunizations and vaccinations for the following reasons: Medicare usually does not pay for this service. **BENEFICIARY NOTICE: The Inflation Reduction Act (IRA)** is legislation that was signed into law in August 2022 with provisions that address wide-ranging issues including healthcare costs, inflation, climate change, and the budget deficit. One notable provision improves access to vaccines by eliminating cost-sharing for beneficiaries with Medicare prescription drug coverage (Part D). Part D plans must reimburse enrollees for any out of-pocket expense for ACIP-recommended adult vaccines administered by both in- and out-of network providers. Healthy Traveler is an out-of-network provider, and does not process claims, and Healthy Traveler as the provider will bill the patient for the entire charge of the administered vaccine. The patient will then submit a claim to their Part D plan for reimbursement. Every Part D plan has their own reimbursement process. Patient is to contact their Part D plan to request a Medicare Part D Prescription Drug Claim Form and instructions for submission.

BENEFICIARY'S ACKNOWLEDGMENT & AGREEMENT TO PAY: Healthy Traveler Clinic has notified me that any and all reimbursement under the eligible medicines and services under the Inflation and Reduction Act will be between myself and my Part D carrier.

INITIALS HERE _____

YOUR PERSONAL RESPONSIBILITY

I agree to fully and truthfully inform the staff of the Healthy Traveler® Clinic of my medical history, including allergies, medications, adverse reactions or medical conditions so the best medical advice possible can be given. I affirm that I understand the risks involved in my travel plans and that I have sought information and counseling to my satisfaction. I agree to hold the Healthy Traveler® Clinic, staff and its affiliates, harmless and free of any liability arising from my personal decision not to follow the recommendation of the Healthy Traveler® Clinic. I understand and accept that I am ultimately responsible for my travel health care decisions.

I have read the above information, understand it and have had any questions about it explained to my satisfaction. I certify that I am of legal age to sign this document or that I have legal rights to give permission for the medical care of the below-named patient and that I have received a copy.

Your Signature _____ Today's Date _____