TRAVELCARE
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Providing full medical services for travelers in the private practice setting of Infectious Disease Physicians

NAME_____DATE_____

ADDRESS_____ZIP_____

HOME PHONE_____WORK #_____

SOCIAL SECURITY NUMBER_____D.O.B_____AGE_____

WEIGHT_____ SEX: Male Female

REFERRED BY_____

PRIMARY CARE PHYSICIAN _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE: _____ALTERNATE PHONE: _____

*****FOR OFFICE USE ONLY*****

PRIMARY INSURANCE: _____

POLICY HOLDERS NAME: _____ D.O.B:_____

ADDRESS: _____ZIP:_____

SECOND INSURANCE: _____

POLICY HOLDERS NAME: _____D.O.B:_____

ADDRESS: _____ZIP:_____

Medical Records Authorization

Date: _____

I authorize the following **individual** to be able to receive my medical information, including, but not limited to test results, appointment confirmation and copies of medical records:
Name: _____

Relationship to Patient: _____

Address:
_____
_____

Phone Number: _____

I understand that this authorization will be valid until I provide Travelcare with written confirmation that I no longer would like this individual to receive my medical information.

Signature: _____
(Patient)

ITINERARY

COUNTRY	DURATION	WHERE WILL YOU STAY	URBAN/RURAL

Date of departure: _____Length of stay: _____

Who will be traveling with you? _____

Will there be children traveling with you; if so, please list names and date of birth for each child:

1. _____
2. _____
3. _____

PLEASE CIRCLE ALL THAT APPLY TO YOUR TRAVEL ITINERARY

MAJOR RESORTS	CRUISE SHIPS	CAMPING
RENTING A FOREIGN HOME	SMALL HOTEL	SAFARI
STAYING WITH FAMILY	YOUTH HOTEL	OUTDOOR ACTIVITIES
CAVE EXPLORATION	DIVING	MOUNTAIN CLIMBING

OTHER (PLEASE SPECIFY) _____

WHAT IS THE PURPOSE OF THIS TRIP: Business, Teacher, Volunteer Program, Vacation/Leisure, Study Abroad, Missionary, Field Work

PRIOR IMMUNIZATIONS

	Y/N	DATE		Y/N	DATE
IMMUNOGLOBULIN			TETANUS DIPTHERIA (TDAP)		
HEPATITIS A OR B			PNEUMOCOCCAL		
JAPANESE ENCEPHALITIS			PLAGUE		
MMR (MEASLES, MUMPS, RUBELA)			POLIO (IPV OR OPV)		
MENINGOCOCCAL			POLIO BOOSTER (ADULT)		
PNEUMOCOCCAL			RABIES		
TYPHOID			YELLOW FEVER		
VARICELLA/ZOSTAVAX			OTHER		

Did you have any adverse reaction to any of the above vaccinations? Yes No

If you were born after 1957, have you had the measles? Yes No

If not, have you been immunized for the measles? Yes No

Have you been exposed to chicken pox, mumps, or rubella? Yes No

INTERNATIONAL TRAVEL MEDICAL QUESTIONNAIRE (Please √ YES or NO)

Immunizations	Yes	No	Problem
Have you ever fainted from having your blood drawn or from an injection?			
Have you ever had a fever reaction to a vaccination?			Any vaccine, especially those containing tetanus-diptheria
Have you ever had any bad reaction/side effect from any vaccination?			
Have you ever had Hepatitis A or B vaccine?			
Do you live (or work closely) with anyone who has AIDS, an AIDS-like condition, any other immune disorder, or who is on chemotherapy for cancer?			Varicella, smallpox, FluMist, MMRV, Zostavax
Do you have a family history of immunodeficiency?			Varicella, smallpox, FluMist, MMRV, Zostavax
Have you received any injection of immune globulin or any blood product during the past 12 months?			Varicella, measles-containing vaccine, smallpox, MMRV, Zostavax
GENERAL MEDICAL	**Yes**	**No**	**Problem**
Do you have a medical condition that warrants maintenance medications or physician follow-up?			
Do you have a medical condition that is stable now, but that may recur while traveling?			
Do you have asplenia?			
Have you had an acute illness or a fever in the past 48 hours?			
Are you pregnant or might become pregnant on this trip?			MMR, oral typhoid, smallpox, varicella, MMRV, yellow fever, FluMist, HPV,Zostavax, BCG, JE, doxycycline and other antibiotics. For other vaccines weigh theoretical risk of vaccination against risk of disease
Are you breastfeeding?			Smallpox, yellow fever
Do you have HIV, AIDS, an AIDS-like condition, immune deficiency or other immune disorder, leukemia, cancer, or are you taking immunomodulatory drugs, or are you post-transplant?			MMR, oral typhoid, smallpox, rabies, varicella, yellow fever, FluMist, MMRV, Zostavax, rotavirus
Do you have severe combined immunodeficiency disease?			Rotavirus
Do you have a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?			Yellow Fever
Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?			Any intramuscular injection

Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?			Mefloquine, DTaP, Tdap, MMRV
Do you have any stomach conditions?			Oral typhoid, mefloquine, doxycycline, Malarone, chloroquine, rotavirus
Do you have a G6PD deficiency?			Chloroquine, primaquine
Do you have severe renal impairment?			Malarone
Do you have a bowel condition such as diarrhea or constipation?			Rotavirus
Do you have congenital malformation of the GI tract or chronic GI disorder?			Rotavirus
Have you ever had hepatitis or yellow jaundice?			

Do you have a history of psychiatric problems?			Mefloquine
Do you have a problem with strange dreams and/or nightmares?			Mefloquine
Do you have insomnia?			Mefloquine
Do you have problems with vaginitis?			Any antibiotic
Do you have psoriasis?			Chloroquine or related compounds
Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis?			Smallpox
Do you have cardiac disease, with or without symptoms?			Smallpox, FluMist
Do you have any eye conditions?			
Are you prone to motion sickness?			
Do you have asthma or wheezing?			FluMist
Do you have multiple sclerosis?			Yellow fever
MEDICATIONS (ARE YOU OR WILL YOU BE TAKING ANY YOU LIST BELOW)	**Yes**	**No**	**Problem**
Quinine, quinidine, or medications for a cardiac conduction defect?			Mefloquine
Chloroquine, mefloquine, or proguanil to prevent malaria?			
Proguanil to prevent malaria?			oral typhoid
Steroids, prednisone, or anti-cancer drugs?			MMR, oral typhoid, varicella, yellow fever, FluMist, MMRV, Zostavax
Antibiotics or sulfonamides?			Oral typhoid
Pepto-Bismol to prevent traveler's diarrhea?			Doxycycline, tetracycline
Antacids?			Doxycycline, tetracycline
Oral contraceptives?			Doxycycline, tetracycline
Aspirin therapy? (children & adolescents)			Varicella, FluMist
Medications for emotional problems?			Mefloquine
ALLERGIES	**Yes**	**No**	**Problem**
Any medications?			
Amphotericin B?			Rabies (PCEC)
Penicillin or sulfa?			Diamox, Fansidar, penicillin, sulfa
Mercury or thimerosal?			See table THIM-1 (U.S.)
Streptomycin?			IPV
Gentamicin?			FluMist, Fluarix
Neomycin?			Hep A, Hep B, Hep A/B, Comvax, DTaP, Td, rabies, varicella, Zostavax, MMRV, Pediarix, smallpox, Kinrix, Pentacel
Polymyxin?			Influenza (Fluvirin, Afluria), IPV, Pediarix, smallpox, Kinrix, Pentacel

ALLERGIES	Yes	No	Problem
Kanamycin?			Agriflu
Sulfites?			Doxycycline
Protamine sulfate?			Ixiaro
Aluminum or aluminum hydroxide?			Hep A, Hep B, Hep A/B, Comvax, DTaP, Td, rabies (RVA), anthrax, PCV, Tdap, TBE, HPV, Kinrix, Pentacel, Ixiaro, Pediarix, Hib, Gardasil
Benzethonium chloride?			Anthrax
2-phenoxyethanol?			Hep A (Havrix), Hep A/B, IPV, DTaP (infanrix, Daptacel), Pediarix, Td, Pentacel
Yeast?			Hep B, Hep A/B, Pediarix, Comvax, PedvaxHib, PCV, oral typhoid, Gardasil, Menveo
Eggs, ovalbumin, or chicken protein?			Influenza, rabies (PCEC), yellow fever, MMR, MMRV, TBE
Chlortetracycline?			Rabies (PCEC)
Latex?			Consult package insert
Are you hypersensitive to gelatin?			Varicella, MMR, DTaP, yellow fever, rabies (PCEC), influenza (Fluzone, FluMist), oral typhoid, MMRV, Zostavax
Are you hypersensitive to soy?			PCV
Are you hypersensitive to lactose?			Menomune, oral typhoid, Hiberix, BCG
Medication for convulsions?			Mefloquine

MEDICATION RECONCILIATION

Pharmacy Name and Phone Number_____

Date	Drug	Strength	Directions/Purpose	Verifier/ Time

GENERAL CONSENT TO TREATMENT

Date: _____

Patient Name: _____

1. CONSENT: I request and authorize care as my physician and his/her designees and assistant may deem necessary or advisable. This includes, but is not limited to, routine diagnostic and laboratory procedures, administration of drugs and other therapeutics, and routine medical, nursing, and hospital care.
2. RELEASE OF INFORMATION: I understand that the confidentiality of all medical records will be protected to the full extent of the law. I authorize Travelcare to release all information from my medical record to:
    a. Any referring or primary care physician, or any health care facilities or physician to which I am referred for the purpose of continuity of care;
    b. Any third party payers, organizations or insurance companies which are responsible, in whole or part, for obtaining third party insurance benefits for me, for billing and/or paying my physician, and for filing appeals of denial of benefits, so that Travelcare may be paid for the services provided to me; and
    c. Any independent auditors or review agencies retained by any third party payers and insurer to analyze the charges for services rendered to me.
1. NO GUARANTEES: I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment, which I have authorized.
2. TESTING AND DISPOSAL OF SPECIMENS AND TISSUES: I authorize Travelcare to retain, preserve, or use for research, scientific or teaching purposes or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

Signature: _____