International Travel Medical Questionnaire

Travel & Immunization Clinic of Portland

Name: _____ Date of Birth: _____ M/F/Other
Last *First* *Month/Day/Year* *Circle One*

Address: _____
Street *City, State* *Zip*

Daytime Phone: _____ Evening Phone: _____ Primary care physician: _____

Emergency Contact: _____
Name *Phone* *Relationship to Patient*

1. Are you pregnant or planning to become pregnant? ☐Yes ☐No
2. Are you breast-feeding? ☐Yes ☐No
3. Are you or any member of your household immune suppressed? ☐Yes ☐No
4. Have you ever fainted from having your blood drawn or from an injection? ☐Yes ☐No
5. Have you received immune globulin/any blood product during the past year? ☐Yes ☐No
6. Have you received any vaccines in the last month? ☐Yes ☐No
7. Do you have thrombocytopenia (low platelet count) or a coagulation disorder? ☐Yes ☐No
8. Have you ever had a convulsion, seizure, epilepsy or neurologic condition? ☐Yes ☐No
9. Have you ever had hepatitis or yellow jaundice? ☐Yes ☐No
10. Do you have a medical condition that may recur while traveling? ☐Yes ☐No
11. Do you have diabetes? ☐Yes ☐No
12. Do you take steroids (Prednisone or other)? ☐Yes ☐No
13. Have you ever had a thymus disorder or dysfunction, including myasthenia gravis, thymoma, thymectomy, or Digeorge syndrome? ☐Yes ☐No
14. Are you feeling sick today, or do you have a high fever? ☐Yes ☐No
15. Have you ever had a bad reaction or side effect from any vaccination? ☐Yes ☐No
16. Are you a smoker, or do you have a history of asthma? ☐Yes ☐No
17. Are you currently on Aspirin therapy? ☐Yes ☐No

Allergies

1. Have you ever had an anaphylactic reaction to a vaccine? ☐Yes ☐No
2. I am allergic to eggs ☐Yes ☐No
3. I am allergic to mercury/thimerosal ☐Yes ☐No
4. I am allergic to sulfa drugs ☐Yes ☐No
5. I am allergic to neomycin ☐Yes ☐No
6. I am allergic to streptomycin ☐Yes ☐No
7. I am allergic to latex ☐Yes ☐No
8. **Do you have any other known allergies?** ☐Yes ☐No

If yes, please list: _____

Current medical problems: _____

Current Medications: _____

ITINERARY **Departure Date:** _____ **Duration of Trip:** _____

Country	Type of Region	How Long?	Purpose of Trip
	☐ Rural ☐ Urban		
	☐ Rural ☐ Urban		
	☐ Rural ☐ Urban		
	☐ Rural ☐ Urban		

***Please list itinerary in chronological order of trip, including any layovers**

Travel & Immunization Clinic of Portland

Patient Rights and Responsibilities

- It is your responsibility to provide us with the information needed to accurately assess your needs. This includes having specific geographic knowledge of all locations in your itinerary.

- It is your responsibility to tell the clinician the exact number of days you will be in each location on your itinerary. The clinician will review your itinerary locations, but will rely on you to provide them with the number of days in each location. WE WILL NOT REVIEW YOUR DATES OF TRAVEL, but instead will rely on you to provide that information.

- While we understand that sometimes your exact itinerary may be vague or unknown, failure to provide us with accurate itinerary information can put you at risk for life threatening illnesses. In some cases it may be necessary for you to have an additional consultation closer to your date of departure. Any additional costs that arise from incomplete itinerary information (i.e. changes to prescriptions or additional consultations) are the sole responsibility of the patient.

- A Yellow Fever vaccine may be required on some visa applications, or to participate in some travel abroad programs. The Yellow Fever vaccine is the ONLY vaccine required for entry by foreign governments at this time. This requirement is intended to keep their countries free of disease, NOT to keep you healthy. All other vaccines may be recommended, but will not be required for entry into a foreign country.

- There is a higher risk of life-threatening illness &/or death at age 60 and over if you receive Yellow Fever vaccine. This affects 1 out of every 40,000 people, with the risk doubling every decade.

- Vaccine recommendations are based on several factors, with the ultimate goal of keeping you healthy. As a patient you have the right to refuse any vaccines you do not wish to receive.

- Immune suppression due to aging, medication, radiation or chronic medical conditions can reduce your response to vaccines. It is your responsibility to inform us if you would like to have lab confirmation of immunity following vaccination.

- You are responsible for payment of vaccines once they are drawn up. If you choose not to receive a vaccine after it has been drawn up, you are still responsible for payment of the vaccine.

- There are two types of Typhoid vaccine (oral or injectable), in most cases our clinicians will recommend the injectable. If you prefer to have the oral, it is your responsibility to make your preference known to your clinician.

- A new consultation is required for each trip. This is necessary because health risks need to be evaluated for each destination. Even if you are traveling to a country that you have been to in the past, the risks may have changed.

- We will prescribe the medications that best meet your medical needs. We are unable to pre-authorize medications with your insurance. If cost of medications is a concern for you, it is important to discuss that with your clinician.

- With few exceptions, prescriptions are **NOT** refillable. If you need a new prescription you need to come in for a new consultation, even if you have been prescribed that same medication by one of our clinicians for a previous trip.

- **By signing this I am acknowledging that I have read and understand my rights and responsibilities as a patient of Travel & Immunization Clinic of Portland.**

_____ _____

Patient Signature (if under 18, parent or guardian) Date

_____ _____

Printed name of individual receiving vaccinations Birth date

Travel & Immunization Clinic of Portland

What concerns would you like to discuss with the Travel Clinician today?

_____

_____

Travel activities which may affect immunization:

Outdoors between dusk to dawn?	☐Yes	☐No	Cave exploration? Spelunking?	☐Yes	☐No
Delivering Health Care?	☐Yes	☐No	Travel to over 9,000 feet?	☐Yes	☐No
Using local health care?	☐Yes	☐No	Close exposure to animals	☐Yes	☐No
Tattoo or other risk to body fluids?	☐Yes	☐No	Veterinary Care	☐Yes	☐No

Immunization History (NOTE: IF YOU BROUGHT YOUR VACCINE HISTORY, YOU CAN SKIP THIS SECTION)

Hepatitis A	☐Yes (date) _____	☐No	☐Don't Remember
Hepatitis B	☐Yes (date) _____	☐No	☐Don't Remember
Influenza (Flu)	☐Yes (date) _____	☐No	☐Don't Remember
Typhoid	☐Yes (date) _____	☐No	☐Don't Remember
MMR	☐Yes (date) _____	☐No	☐Don't Remember
Tetanus	☐Yes (date) _____	☐No	☐Don't Remember
Adult Polio	☐Yes (date) _____	☐No	☐Don't Remember
Meningococcal	☐Yes (date) _____	☐No	☐Don't Remember
Pneumococcal	☐Yes (date) _____	☐No	☐Don't Remember
Shingles	☐Yes (date) _____	☐No	☐Don't Remember
Yellow Fever	☐Yes (date) _____	☐No	☐Don't Remember
Varicella (Chicken Pox)	☐Yes (date) _____ Disease as child (date) _____	☐No	☐Don't Remember

Vaccine Consent Form

I understand and consent to receive the vaccinations that I approve during my consultation. I understand that receiving these injections does not guarantee that I will not become infected by an illness while I am traveling, or guarantee health in any way. Further, I understand that none of the vaccinations I am being given are 100% effective in preventing the diseases, which they are designed to prevent.

I understand that vaccinations have potential side effects including death in rare cases. I acknowledge that I will not receive any vaccinations until I have discussed the risks and side effects of these vaccines with a Travel & Immunization Clinic of Portland representative and fully understand the risks of each vaccine I have agreed to receive.

I understand that various countries change their vaccination requirements for entry into their borders. While Travel & Immunization Clinic of Portland does receive frequent updates on the constantly changing vaccination requirements for most countries of the world, I acknowledge and agree not to hold Travel & Immunization Clinic of Portland or any of its agents liable if I am denied entry into or am placed in quarantine in any country to which I am traveling. Further, I understand my travel vaccinations were determined, in part, by the travel itinerary which I provided to Travel & Immunization Clinic of Portland, and that any changes to my travel itinerary may completely change the immunizations required to enter any country to which I may be traveling.

I understand that Travel & Immunization Clinic of Portland is providing me with travel vaccinations only and that I am responsible for any medical costs associated with treatment of reactions to vaccinations as well as any medical costs associated with treatment of any illness acquired while traveling or at home.

Your signature below indicates that you have read and agree with all items printed above.

_____ _____

Patient Signature (if under 18, parent or guardian) Date

_____ _____

Printed name of individual receiving vaccinations Birth date

Travel & Immunization Clinic of Portland

Patient Responsibility:
Patients are responsible for all charges resulting from services provided by Travel & Immunization Clinic of Portland. Payment is due in full at time of service

Office Visit Fees & Definitions:

- Office Visit $74.99
  - Office visits include a combination of the following services: consultation with a clinician, prescriptions for medications, travel advice, vaccination recommendations, coordination of care with your personal physician, travel health education.

- Injection Fee $19 for first injection, $12 for any subsequent injections

- Booster Discount
  - Existing patients returning for series boosters of Hep A, Hep B, Japanese Encephalitis, MMR, Rabies, Shingles, or Twinrix are eligible to receive a discount on their office visit. The discount applies only to boosters for existing trips in cases where no consultation with a clinician, prescriptions for medications, travel advice, vaccination recommendations, coordination of care with your personal physician or travel health education are provided.

Each Time You Visit the Clinic you will be charged for:

- An office visit
- An injection fee for each vaccine you receive
- A separate charge for each vaccine you receive

------ All Vaccine Prices are per dose ------

Vaccinations	# of Doses in series	Price per dose
Hepatitis A	2	$99.99
Hepatitis B	3 or 4	$99.99
Influenza	1	$36.95
Japanese Encephalitis	2	$379.99
Meningococcal (Menveo)	1	$179.99
MMR	2	$115.99
Pneumococcal	1	$164.99
Polio (IPV)	1	$79.99
PPD – TB Skin Test	1	$71.95
Rabies	3	$389.99
Shingles (Shingrix)	2	$219.99
Tetanus (Tdap)	1	$71.95
Twinrix (Hep A&B)	3 or 4	$159.99
Typhoid Oral	1	$124.99
Typhim Vi	1	$104.99
Varicella	1	$179.99
Yellow Fever	1	$249.00
Cholera Oral	1	$379.99

Series Vaccines (Hep A, Hep B, Japanese Encephalitis, MMR, Rabies, Shingles, or Twinrix):
If you start a vaccine that requires multiple shots, we will only charge you for the shots you receive on each visit. This is to prevent charging you for a series that you may not complete at our clinic. If you would like to prepay for your series vaccine please ask the receptionist upon checkout.

Travel & Immunization Clinic of Portland

Billing Errors:

- Invoices presented at time of service are preliminary bills and are subject to audit. Balance due must be paid within 10 (ten) days. Credits will be applied to your account or refunded.

Insurance Billings:

- We do not bill insurance.
- Medicare: We do not bill Medicare.

Appointment Cancellation: We require 24 hours notice for appointment cancellations and rescheduling. If you cancel or reschedule without 24 hours notice you will be billed for the missed appointment. We do not accept cancellations or rescheduling via email or voicemail. You must speak with a staff member to authorize the cancellation or to reschedule.

Authorization to Release Information:
I have read and accept this credit/financial policy for my treatment with Travel and Immunization Clinic of Portland. If I have been referred by, or I am being referred to another healthcare provider, I authorize my provider or my provider's staff to release my clinical information to this provider for continuing care.

Guarantee of Financial Responsibility
I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances are due at time of service.

I, or my appointed agent, have read, fully understand and agree to the above statements. I have received a copy of this information (upon request).

_____ _____
Patient Signature (if under 18, parent or guardian) Date

_____ _____
Printed name of individual receiving vaccinations Birth date

Travel & Immunization Clinic of Portland

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

For Notice with Effective Date: April 14, 2003

PLEASE REVIEW THIS ACKNOWLEDGEMENT CAREFULLY, THEN SIGN AND DATE BELOW.

The Notice of Privacy Practices tells you how Travel and Immunization Clinic of Portland may collect, use or disclose health information about you, and tells you about your privacy rights. The clinic is required to give you a Notice of Privacy Practices by federal law. Copies are available at the front desk, and are also posted on the wall of the waiting room.

I, _____,
Client's printed name

have been given a copy of Travel and Immunization Clinic of Portland's Notice of Privacy Practices and have had a chance to ask questions about how my health information will be collected, used and disclosed and how to access my privacy rights.

_____ _____
Client's Signature *Date*

_____ _____
Legal or Personal Representative of Client (if applicable) *Relationship*

CLINIC USE ONLY

Client was provided a copy of the TICP Notice of Privacy Practices, but I was unable to obtain a signature because:

_____

_____

Employee: _____ Date: _____