CARSON VALLEY HEALTH

TRAVEL HEALTH SERVICES: PATIENT INFORMATION FORM

NAME: _____ DATE OF BIRTH: _____

SEX: male / female OCCUPATION:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

PRIMARY CARE PROVIDER: _____ ADDRESS:_____

PLEASE PRESENT A COPY OF YOUR IMMUNIZATIONS RECORDS. THESE NEED TO BE SUBMITTED ALONG WITH THIS FORM PRIOR TO SCHEDULING YOUR APPOINTMENT.

TRAVEL DEPARTURE DATE: _____ RETURN DATE: _____

LIST IN ORDER COUNTRIES TO BE VISITED *Include countries that you will be flying/docking/driving into/out of	SPECIFIC REGION OF COUNTRY	LENGTH OF STAY

REASON FOR TRIP: ☐ Business ☐ Tourist ☐ Student ☐ Mission ☐ Other: _____

ACCOMODATIONS: ☐ Hotel ☐ Hostel ☐ Private Home ☐ Camping ☐ Cruise ☐ Local home (family/friends/rental) ☐ Other: _____

Are you planning to travel outside of urban areas? YES NO

Are you planning to go hiking, backpacking, or swimming? YES NO

Are you planning to go scuba diving? YES NO

HEALTH HISTORY INFORMATION

Do you have:

Heart disease or high blood pressure	YES	NO
Lung disease/COPD/asthma	YES	NO
Diabetes	YES	NO
Skin disease/disorder	YES	NO
Mental illness/depression/anxiety	YES	NO
Seizure disorder/epilepsy	YES	NO
Bleeding disorder, or take anticoagulants	YES	NO
Thymus dysfunction/tumors/thymectomy	YES	NO
Immune disorder/cancer/HIV	YES	NO

Please explain any YES answers: _____

_____

Have you taken any steroids or chemotherapy drugs in the last 3 months? YES NO
Do you LIVE WITH someone who is taking steroids or chemotherapy drugs? YES NO
Do you LIVE WITH someone who has cancer or HIV? YES NO
During your travel(s) are you planning to have any medical, dental or cosmetic procedures? YES NO
Have you ever had an adverse reaction to a vaccination? YES NO
Have you received any vaccination(s) within the last 30 days? YES NO
Please explain any YES answers:_____

_____

CIRCLE any allergies that you have: eggs / latex / yeast / mercury (Thimerosal) / gelatin / bee stings
List allergies to medications: _____

_____

List any other allergies: _____

_____

Current medications: _____

_____

WOMEN ONLY:

Are you pregnant or trying to become pregnant? _____ If 'yes' how far along? _____
Last Menstrual Period _____ Are you breastfeeding? _____

Consent for services: I understand that, while remarkably safe, vaccines can, in rare instances, cause complications including death. I agree to accept this risk in order to decrease my chances of contracting a serious preventable disease. I also understand that Carson Valley Health Occupational Health Services does not file claims for, nor accept any form of insurance payment for travel visits. I understand that my health insurance is a contract between me and my insurance company. I understand that Carson Valley Health Occupational Health Services will not refund any difference between my insurance reimbursement and Carson Valley Health Occupational Health Services charges. I certify that the above information is correct.

Print Name: _____ Date: _____

Signature: _____

CARSON VALLEY **HEALTH**

TRAVEL INTAKE FORM

DATE OF CALL: _____ NAME(s): _____

BEST PHONE #: _____Email: _____

TRAVEL DATES: _____

*Please inform that paperwork needs to be submitted along with pertinent paperwork (i.e.: vaccination history) prior to an appointment being scheduled, so that the provider may review, and we can ensure we have the vaccinations in stock.

DESTINATION(s): _____

_____

_____

*Inquire if patient is aware of REQUIRED vaccinations to their destination (i.e.: yellow fever, Japanese encephalitis, typhoid). We **do not** carry or order: yellow fever or Japanese encephalitis.

APPOINTMENT INFORMATION

- ☐ Single individual exam $65.00
- ☐ Per extra person per exam $45.00

*Some vaccines listed may require multiple doses and will be determined by the provider at the time of service

VACCINATION	COST
FLU	45.00
HEP A	133.00
HEP B	97.00
TWIN RIX A & B	171.00
TYPHOID *we need to pre-order for appointment	110.00
MMR	102.00
POLIO	67.00
TETANUS	121.00
VARICELLA	141.00

Estimated Total: _____

By signing below, you are acknowledging that the total cost is an estimate and is subject to change should additional vaccinations be administered

Signature: _____ Date: _____