Central Vermont Home Health & Hospice
A Century of Caring and Quality

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International Travel Health Program

Diana Daugherty, LPN

INTERNATIONAL TRAVEL CLINIC

Date of Scheduled Appointment: _____

Name: _____ DOB: _____Age:____Gender: _____

Address: _____

Phone number: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

Primary Physician: _____ Phone # : _____

Country of Birth: _____ Date of Immigration to U.S.: _____

TRAVEL INFORMATION

Departure Date: _____Return Date: _____ Total Length of Trip:_____

Number of people traveling with you: _____ OR, in your Group: _____

ITINERARY: (List Countries in Order of Travel)

Country	**CityArea**	**Country**	**City/Area**
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

PURPOSE OF TRIP: (Check all that apply)

__ Business __Vacation __ Missionary __ Adoption

__ Humanitarian __ Visit Family/Friends __ Other:_____

TYPE OF TRAVEL: (Check all that apply)

__ Guided/Escorted __ Rural __ Fixed Itinerary __ Usual Tourist Areas

__ Independent __Major Cities __ Flexible Itinerary __ Unusual Tourist Areas

Check any of the following ACTIVITIES that apply to your trip:

__ Provide Medical Care __ Ocean/Salt Water __ Cruise Ship Travel

__ Field Work __ Scuba Diving/Snorkeling __ Caving (Spelunking)

__ Animal Handling __ Bicycling __ Camping

__ Tour Bus __ Rafting/Kayaking __ Trekking

__ Fresh Water/Rivers/Lakes __ Diving/Swimming/Wading

__ Sun Bathing/Exposure __ Altitude >10,000/ft (3040m)

__ Vehicle Travel or Rental __ Other (please comment) _____

Check any items that you would like to discuss:

__ Risk of Malaria __ Travelers Diarrhea

__ Risk of Blood Borne Infections __ Motion Sickness

__ Food and Water Safety __ Risk of Sexually Transmitted Diseases

__ Recommended and required vaccines __ Jet Lag

__Insect-borne disease __ Other _____

Will your medical insurance cover illness/accidents abroad?

__ Yes __ No Name of Insurance Carrier _____

Do you have medical evacuation insurance?

__Yes __ No

PERSONAL MEDICAL INFORMATION

Do you have any allergies?

__Yes __No

If YES, please choose from the following list:

__ Hay fever/Pollens __Bee Stings

__ Shellfish __ Foods_____

__ Thimerosol __ Nuts

__ Eggs __Other_____

__Medications _____

__Previous Vaccinations _____

__Other _____

Please explain your reaction(s) to any of the above marked allergies:

_____

_____

Have you received gamma globulin or blood transfusions within the past year?

__ Yes __ No If yes, please explain: _____

Are you pregnant?

__ Yes __ No __ N/A

If yes, __1st __2nd __3rd Trimester (check one)

Is Pregnancy a possibility prior or during this trip? __ Yes __ No __ N/A

Are you breastfeeding? __ Yes __ No __ N/A

Date of last menstruation: _____

Check if you have had any of the following diseases or medical problems:

__ Hepatitis A __Epilepsy __ Insulin diabetes __ Heart attacks
__ Hepatitis B __ Seizures __ Kidney failure/diabetes __ Heart Disease
__ Hepatitis C __ Chickenpox __ Blood thinning meds __ HIV/AIDS
__ Irregular heart rhythms __ Splenectomy
__ History of thymus disease __ Blood thinning meds
__ Problems treated with immunosuppressive medications (cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis).
__ Other (list below)

_____

Date of last tuberculosis skin test: _____ Result: _____

Do you have a history of factors that may make you at risk for HIV, AIDS, or Hepatitis B? (i.e. blood transfusions, risky homosexual or heterosexual contacts, use of shared or un-sterile needles for injections of drugs or medication, tattoos, acupuncture, injections given in developing countries.)

___ YES ___ NO ___ UNKNOWN

Please list current medications:

	Name of medication	Dosage	Reason for taking
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

IMMUNIZATION HISTORY:

DPT (Diptheria,Pertussis,Tetanus)	Date of last immunization:	_____
MMR (Measles, Mumps, Rubella)	Date of last immunization:	_____
Polio/IPV/OPV	Date of last immunization:	_____
TD (Tetanus/Diptheria)	Date of last immunization:	_____
Chickenpox (Varicella)	Date of last immunization:	_____
Hepatitis B (1-2-3)	Dates of immunizations:	_____
Hepatitis A (1-2)	Dates of immunizations:	_____
Hepatitis A & B (1-2-3)(twinrix)	Dates of immunizations:	_____
Pneumovax	Date of last immunization:	_____
Influenza	Date of last immunization:	_____
Meningococcal	Date of immunization:	_____
Rabies	Date of immunizations:	_____
Typhoid (Typhim Vi)	Date of immunization:	_____
Yellow Fever	Date of immunization:	_____
Japanese Encephalitis	Date of immunization:	_____
Typhoid oral	Date of last dose:	_____

Are you up to date on all your childhood immunizations?

___ Yes ___ No

_____ _____

Signature of Client Requesting Travel Health Services Date

For Travel Clinic Specialist Use Only

Recommended Travel Immunizations:

Handouts and informational material given:

Recommended prescriptions:

Referrals to PCP or other MDS/facilities:

International Certificate of Vaccination given: ___ YES ___ NO

Post-Consult visit set up? ___ Yes ___ No

Notes/Comments:

_____ _____

Signature of Travel Clinic Coordinator ***Date***