# Southwest Utah Public Health Department
# International Travel Intake Form

***All information is strictly confidential***

***(Please Print)***

Today's Date: _____

STAMARIL Patient ID: _____

**CLIENT INFORMATION:**

Name: _____ Mother's Maiden Name: _____
LAST FIRST MIDDLE

Address: _____
STREET/P.O. BOX CITY STATE ZIP CODE

Telephone: (_____) _____ - _____ ☐ Home ☐ Cell ☐ Message ☐ Work

Telephone: (_____) _____ - _____ ☐ Home ☐ Cell ☐ Message ☐ Work

Email: _____

Birth Date: _____ / _____ / _____ Age: _____ Gender: ☐ Male ☐ Female
MO DY YR

Race: ☐ White ☐ Black ☐ Asian ☐ Indian/American Native ☐ Native Hawaiian/Pacific Islander ☐ Other
Hispanic/Latino: ☐ Yes ☐ No

If child, name of parent: _____

**INSURANCE INFORMATION**: (Please bring current insurance card at time of service)

Medicaid: ☐ Yes ☐No ID# _____

Medicare: ☐ Yes ☐No ID# _____

Private Insurance: ☐ Yes ☐No

Insurance Co. Name: _____ ID Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Does your insurance cover the cost of immunizations? ☐ Yes ☐ No ☐ Unknown

## CONSENT FOR TREATMENT AND PRIVACY NOTICE

I, the patient (or the undersigned if other than the patient), understand that I am responsible for all expenses incurred at the Southwest Utah Public Health Department (SWUPHD) International Travel Clinic on my behalf (or on behalf of the patient). SWUPHD may be able to bill my health insurance, Medicare/Medicaid, but I understand that I am responsible for all co-payments, deductibles, immunizations, counseling fees, and other services not covered by my health insurance, Medicare/Medicaid. I agree to pay all fees at time of service.

I have been given a copy and have read, or have had explained to me, the information contained in the important Vaccine Information Statements. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the vaccines indicated be given to the person named above for whom I am authorized to make this request. I agree that immunization information (only) may be included in a centralized, statewide database and shared with other health care providers as necessary. I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS, TRAVEL ADVICE AND PRESCRIBED MEDICATIONS.

I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature: _____ Today's Date: _____

Relationship to Client: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other _____

## TRAVEL INFORMATION

Departure Date: _____ Return Date: _____ Total length of trip: _____

Number of people traveling with you: _____ or number in your tour group _____

**ITINERARY:** ***(Please list in order and include length of time you will be staying at each location including airport stops and layovers)***:

| | Country | City/Area | Duration | | Country | City/Area | Duration |
|---|---|---|---|---|---|---|---|
| 1. | | | | 4. | | | |
| 2. | | | | 5. | | | |
| 3. | | | | 6. | | | |

**PURPOSE OF TRIP** ***(check all that apply)*****:**
□ Business/work □ Receive medical care □ Provide medical care □ Visit family/friends □ Adoption □ Vacation
□ Non-LDS mission/humanitarian □ LDS mission–MTC location _____ *(skip to Personal Medical Info section)*
□ Other _____

**TYPE OF TRAVEL** ***(check all that apply):***
□ Guided/escorted tour □ Rural areas □ Fixed itinerary □ Usual tourist areas
□ Independent travel □ Urban/major cities □ Flexible itinerary □ Unusual tourist areas

**PLANNED ACCOMMODATIONS:**
□ Hotel 5 - 3 star □ Live with locals/private home □ Camping
□ Local apartment □ Cruise ship □ Hostels
□ Dorm style lodging □ Remote location □ _____

**ACTIVITIES (check all that apply to your trip):**
□ Tour bus □ Ocean/salt water □ Altitude above 8,000 ft (2500 m) □ Animal contact/hunting
□ Automobile travel □ Scuba diving □ Sun exposure □ Field work
□ Motorcycle/bicycling □ Fresh water; rivers/lakes □ Caving (spelunking) □ Safari
□ Cruise ship travel □ Rafting/kayaking □ Camping/hiking □ _____

**Check any items you would like to discuss:**
□ Altitude sickness □ Risk of malaria □ Food & water safety □ Seeking medical care
□ Insect borne diseases □ Travelers' diarrhea □ Motion sickness □ Other _____
□ Risk of blood borne infections □ Air travel/jet lag □ Medical care/evacuation insurance

## PERSONAL MEDICAL INFORMATION

□ YES □ NO Have you previously traveled to any developing country?
□ YES □ NO Did you receive your childhood vaccines?
□ YES □ NO Have you ever had chickenpox disease or the vaccine series? If yes, which one: _____
□ YES □ NO Are you currently under a physician's care for <u>any</u> health problem?
□ YES □ NO Do you smoke?
□ YES □ NO Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?
□ YES □ NO Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation treatment in the last 3 months?
□ YES □ NO Do you have any seizure or brain problems?
□ YES □ NO Have you received gamma-globulin or blood transfusions within the past year?
□ YES □ NO Have you received any vaccinations or a TB test in the past 4 weeks?
□ YES □ NO Have you ever taken anti-malarial medication? If yes, what medication: _____
Did you tolerate it well? □ Yes □ No
□ YES □ NO Are you, or will you be at risk for blood borne infections such as: HIV, AIDS, or Hepatitis B or C?
Risks include: blood transfusions, unprotected sexual contacts, use of shared or unsterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.
□ YES □ NO *(Females)* Are you pregnant or planning on pregnancy? If yes, when: _____
□ YES □ NO *(Females)* Are you currently breastfeeding? If yes, how old is the infant: _____

## ALLERGIES

□ YES □ NO Have you ever had a serious or life threatening allergic reaction?
□ YES □ NO Are you allergic to any of the following?
□ Sulfa □ Neomycin □ Streptomycin □ Polymyxin B □ Eggs □ Baker's Yeast □ Gelatin □ Bee Stings
OTHER ALLERGIES: please list: _____

## MEDICAL HISTORY □ NONE

(check all that apply)

| | | | |
|---|---|---|---|
| □ Hepatitis/liver disorders | □ Myasthenia gravis | □ Prostate problems | □ Diabetes |
| □ Thrombophlebitis/blood clots | □ Seizures/epilepsy | □ Kidney disease | □ Heart disease/attacks |
| □ Recurrent pneumonia | □ Mental/emotional illness | □ Irregular heart rhythms | □ HIV or AIDS |
| □ Splenectomy | □ Thymus disease/thymectomy | □ Blood thinning meds | □ Psoriasis |
| □ Stomach or bowel conditions | □ Retinal or visual field changes | □ Recent surgeries | □ _____ |

□ Conditions treated with immunosuppressive medications: such as cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohn's, ulcerative colitis

## MEDICATION INFORMATION □ NONE

*(Include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)*

| Medication | Reason for Taking | Medication | Reason for Taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**STOP!** **DO NOT WRITE BELOW – FOR OFFICE USE ONLY** **STOP!**

## IMMUNIZATION INFORMATION

| VACCINE | Date of last immunization | Recommend | D / D | VACCINE | Date of last immunization | Recommend | D / D |
|---|---|---|---|---|---|---|---|
| Chickenpox (Varicella) | | | | Pneumococcal 23 | | | |
| Cholera | | | | Prevnar 13 | | | |
| Gamma Globulin | | | | Polio IPV/OPV | | | |
| Hepatitis A (0, 6 mo) | | | | Rabies | | | |
| Hepatitis B (0, 1, 6 mo) | | | | Tetanus/Diphtheria Td | | | |
| Hepatitis A & B (Twinrix) (0, 1, 6 mo) (0, 7, 21 d, 12 mo) | | | | Tetanus/Diphtheria/Pertussis Tdap | | | |
| Human Papillomavirus (HPV) (0, 2, 6 mo) | | | | Typhoid Oral | | | |
| Influenza | | | | Typhoid Injectable | | | |
| Japanese Encephalitis | | | | Yellow Fever | | | |
| Meningococcal | | | | Shingles | | | |
| MMR (0, 1 mo) Measles, Mumps, Rubella | | | | | | | |

D/D = Discussed/Declined
1 = Not covered by insurance
2 = Pt feels don't need it
3 = Personal beliefs
4 = Side effects
5 = Will get/has from PCP
6 = Not enough time before travel
7 = Will get at destination

C = Completed Series Hx = History of Disease

V1 = Visit Date: _____
V2 = Visit Date: _____
V3 = Visit Date: _____

Malaria prophylaxis recommended □ YES □ NO, patient at low/no risk
Prescription given? □ YES □ NO