



Southwest Utah Public Health Department
International Travel Intake Form
All information is strictly confidential
(Please Print)

Today's Date: _____

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

Are you Hispanic/Latino? Yes No

Race: White Black Asian Indian/American Native Native Hawaiian/Pacific Islander Other

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):

<u>Country</u>	<u>City/Area</u>	<u>Duration</u>	<u>Country</u>	<u>City/Area</u>	<u>Duration</u>
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 Are you sick today (with moderate to severe fever or acute illness)?
- 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 any 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 or chicken protein Baker's Yeast Gelatin Bee Stings
 OTHER ALLERGIES: please list: _____

MEDICAL HISTORY

(check all that apply)

- Conditions treated with immunosuppressive medications: such as cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohn's, ulcerative colitis
 Hepatitis/liver disorders Seizures/epilepsy Heart disease/attacks Thymus dysfunction (including myasthenia gravis, thymoma, thymectomy)
 Thrombophlebitis/blood clots Mental/emotional illness Diabetes Retinal or visual field changes
 Recurrent pneumonia Prostate problems HIV or AIDS Blood thinning meds Psoriasis
 Splenectomy Kidney disease Recent surgeries **NONE**
 Stomach or bowel conditions Irregular heart rhythms

MEDICATION INFORMATION NONE

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

Medication	Reason for Taking

Medication	Reason for Taking



DO NOT WRITE BELOW – FOR OFFICE USE ONLY



IMMUNIZATION INFORMATION

VACCINE	Date of last immunization	Recommend	D / / D	VACCINE	Date of last immunization	Recommend	D / / D
Chickenpox (Varicella)				MMR Measles, Mumps, Rubella			
Cholera				Pneumococcal 23			
COVID-19 Moderna / Pfizer / Janssen				Pevnar 13 / 15 / 20			
Hepatitis A				Polio IPV / OPV			
Hepatitis B				Rabies			
Hepatitis B – Heplisav-B (0d, 28d)				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 Zostavax / Shingrix			
MenB							

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

PRESCRIPTIONS

Weight: _____ lbs/kg **NO PRESCRIPTIONS GIVEN**

Rx	Dosage	D/D
<input type="checkbox"/> Acetazolamide (Diamox)	#	
<input type="checkbox"/> 250 mg tab <input type="checkbox"/> 2.5 mg/kg po bid = _____ mg/cap Take ½ to 1 tab/cap bid for prevention of AMS		
<input type="checkbox"/> Atovaquone/Proquanil (Malarone)	#	
<input type="checkbox"/> 250/100 mg tab <input type="checkbox"/> Take 1 tablet po qd starting 1 day prior to travel to malaria area. Continue taking qd during and x 7 days after leaving area for prevention of malaria. Take with food. <input type="checkbox"/> Take _____ tablet(s) po qd x 3 days for self-treatment of malaria. Pediatric Dosing: <input type="checkbox"/> 62.5/25 mg tab <input type="checkbox"/> Take _____ tablet(s) po qd starting 1 day prior to travel to malaria area. Continue taking qd during and x 7 days after leaving area for prevention of malaria. Take with food.		
<input type="checkbox"/> Azithromycin (Zithromax)	#	
<input type="checkbox"/> 250 mg Z-pak <input type="checkbox"/> 200 mg/5 ml (10 mg/kg po qd = _____ ml qd) <input type="checkbox"/> Dispense: <input type="checkbox"/> 15 ml <input type="checkbox"/> 22.5ml <input type="checkbox"/> 30 ml Take _____ tab/dose po qd at onset of travelers' diarrhea x 1-3d or until sx resolve.		
<input type="checkbox"/> Cefdinir (Omnicef)	#	
<input type="checkbox"/> 300 mg tab <input type="checkbox"/> 125 mg/5 ml (7 mg/kg po bid = _____ ml q bid) Take 1 tab/dose po bid at onset of travelers' diarrhea x 1-5d or until sx resolve.		
<input type="checkbox"/> Chloroquine Phospate (Aralen)	#	
<input type="checkbox"/> 500 mg tab <input type="checkbox"/> 8.3 mg/salt kg po q wk = _____ mg/cap q wk. Mix content of cap w/ food. <input type="checkbox"/> Take 1 tab/dose po starting 1 week prior to travel to malaria area. Cont. taking weekly during travel in, and x 4 weeks after leaving malaria area. <input type="checkbox"/> Take 1 tab/dose po in the AM, then 1 tab six hours later starting 1 day prior to travel to malaria area. One week after first dose, start taking 1 tab weekly for every week of travel in, and x 4 weeks after leaving malaria area.		
<input type="checkbox"/> Ciprofloxacin (Cipro) 500 mg tab	#	
Take 1 tab po bid at onset of travelers' diarrhea x 1-3d or until sx resolve.		
<input type="checkbox"/> Dexamethasone (Decadron) 4 mg tab	# 10	
Take 1 tab po qid until sx improve or pt is down, for tx of AMS.		
<input type="checkbox"/> Doxycycline 100 mg tab	#	
<input type="checkbox"/> Take 1 tablet po daily starting one day prior to travel to malaria area. Cont. taking qd during travel in and x 4 weeks qd after leaving malaria area. <input type="checkbox"/> Take 2 tabs po once a wk starting the day of fresh water exposure, continue weekly during and 1 wk following exposure.		
<input type="checkbox"/> Doxycycline 100 mg tab (missionaries)	# 28	
<i>(Only missionaries traveling to malaria area/code #4)</i> <input type="checkbox"/> Take 1 tablet po qd starting two days prior to leaving the United States. Take with food.		
<input type="checkbox"/> Fluconazole (Diflucan) 150 mg tab	#	
Take 1 tab po q wk prn for treatment of yeast infection.		
<input type="checkbox"/> Levofloxacin (Levaquin) 500 mg tab	#	
Take 1 tab po qd at onset of travelers' diarrhea x 1-5d or until sx resolve.		

Rx	Dosage	D/D
<input type="checkbox"/> Mefloquine (Lariam)	#	
<input type="checkbox"/> 228 mg base/250 mg salt tab <input type="checkbox"/> 228 mg base/250 mg salt (4.6 mg base/kg = _____ mg/cap) Mix content of cap w/ food. <input type="checkbox"/> Take _____ tab/dose po once weekly starting 2 weeks prior to travel to malaria area. Cont. taking dose once weekly during travel in and x 4 weeks after leaving malaria area. Take w/ food. <input type="checkbox"/> Take tab/dose po daily x 3 days starting three days prior to travel to malaria area. One week after first dose, start taking dose po weekly during travel in and x 4 weeks after leaving malaria area. Take w/ food.		
<input type="checkbox"/> Nifedipine 10 mg tab	# 10	
Take 1 tab po initially, then 2 tabs bid for tx of HAPE.		
<input type="checkbox"/> Promethazine (Phenergan) 25 mg tab	#	
Take 1 tab po bid prn to prevent motion sickness/nausea. Start medicine ½ - 1 hour before needed.		
<input type="checkbox"/> Ramelteon (Rozerem) 8 mg tab	# 10	
Take 1 tab po at bedtime prn for sleep.		
<input type="checkbox"/> Scopolamine Transderm Pk/4 patches	#	
Apply to bare skin behind 1 ear to prevent motion sickness. Place patch 4 hrs before needed.		
<input type="checkbox"/> Scopolamine 0.4 mg tab	#	
Take 1-2 tab po q 6 hrs prn to prevent motion sickness.		
<input type="checkbox"/> Scopolamine Gel 0.25 mg	#	
Apply 0.1 ml to wrist q 6 hrs to prevent motion sickness. Take dose 1 hr before event.		
<input type="checkbox"/> Xifaxan (Rifaximin) 200 mg tab	#	
Take 1 tab po tid at onset of travelers' diarrhea x 1-3d or until sx resolve.		
<input type="checkbox"/> TMP/SMX (Bactrim)	#	
<input type="checkbox"/> 160/800 mg DS tab <input type="checkbox"/> 80/400 mg SS tab <input type="checkbox"/> 40/200 mg/5 ml (4 mg TMP/kg po bid = _____ ml bid) Take 1 tab/dose po bid at onset of travelers' diarrhea x 1-5d or until sx resolve.		
<input type="checkbox"/> Artemether/lumifantrine (Coartmen)	# 24	
Take _____ tablets po as initial dose, then _____ tablets 8 hours later, then _____ tablets bid on days 2 and 3 for self-treatment of malaria. Take w/ food.		
<input type="checkbox"/> Graduated compression stockings	# 1	
Wear during long distance travel to prevent DVT/PE.		
<input type="checkbox"/>	#	

D/D = Discussed/Declined

1 = Not covered by insurance/\$\$	5 = Will get/has from PCP
2 = Pt feels doesn't need it	6 = Not enough time before travel
3 = Personal beliefs	7 = Will get at destination
4 = Side-effects	8 = Already has prescription

Key: d-day, wk-week, qd-every 24 hours, bid-every 12 hrs, tid-every 8 hrs, qid-every 6 hrs, po-by mouth, prn-as needed, sx-symptoms

WRITTEN/VERBAL/ELECTRONIC EDUCATION

- TRAVAX report for countries visiting
- Immunizations
- Food & water safety
- Traveler's diarrhea
- Insect precautions
- Jet lag/air travel/DVT
- Travel video
- U of U International Travel Clinic Book
- Motion sickness
- Sun protection
- Sexual contacts
- Animal bites
- Fresh water exposure/leptospirosis
- VIS's for vaccines given
- Theft/personal safety
- Health issues
- Travel, health, and medical insurance
- Travel schedule/money/passports
- Illness back home

REGION SPECIFIC / OTHER EDUCATION

- Altitude sickness
- Anthrax
- Arboviral
- Avian flu
- Bartonellosis
- Brucellosis
- Chikungunya
- Children
- Cholera
- COVID-19
- Dengue fever
- Ebola virus
- Enterovirus
- Filarial infection
- Hantavirus
- Helminths
- Hepatitis C
- Japanese encephalitis
- Lassa fever
- Leishmaniasis
- Leptospirosis
- Lyme
- Malaria
- Melioidosis
- Meningococcal
- MERS Coronavirus
- MMR
- Ocean/beach
- Plague
- Pregnancy
- Rabies
- Rickettsial infection
- Schistosomiasis
- Scuba diving
- STIs
- Tick-borne diseases
- Travelers diarrhea
- Trypanosomiasis
- Tuberculosis (TB)
- Typhoid
- Viral hemorrhagic
- West Nile
- Yellow fever
- Zika
- _____

TYPHOID

- Yes No Typhoid vaccine given
- Yes No Education

YELLOW FEVER

- NOT APPLICABLE
- Yes No Meets criteria for yellow fever vaccine
- Yes No International Certificate of Vaccine or Prophylaxis (ICVP)
- Yes No Observed client for 15 minutes
- Yes No Issued waiver for yellow fever vaccine

Notes: _____

Nurse: _____ Date: _____

Reviewed by: _____ Date: _____