



# Southwest Utah Public Health Department

## International Travel Intake Form

All information is strictly confidential

Today's Date: \_\_\_\_\_

Patient Last Name		First Name		MI	Date of Birth (mm/dd/yyyy)		Age
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Pacific Islander			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic		Language		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address					City	State	Zipcode
Primary Phone #		Best Form of Contact <input type="checkbox"/> Phone Call <input type="checkbox"/> Text <input type="checkbox"/> Email		Email:			
Primary Health Insurance			Policy #		Policy Holder (Exact Name listed on Card)		
Insurance Policy Holder Date of Birth (mm/dd/yy)			Relationship to Patient		Address of Policy Holder		
<p>I certify that the information I have provided is true and accurate. 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 this information may be shared with schools, day care centers, health care providers and others when deemed medically necessary. I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS.</p> <p>I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.</p> <p>We are required to inform you of our privacy practices for the information we collect and keep about you. 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.</p>							
Full Name: _____		Signature: _____			Date: _____		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other							

### SECTION 1: 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 your itinerary in order and include the length of time you will be staying at each location including airport stops and any layovers.

<u>Country</u>	<u>City/Area</u>	<u>Duration</u>	<u>Country</u>	<u>City/Area</u>	<u>Duration</u>
<input type="checkbox"/> See attached itinerary			4. _____	_____	_____
1. _____	_____	_____	5. _____	_____	_____
2. _____	_____	_____	6. _____	_____	_____
3. _____	_____	_____	7. _____	_____	_____

**PURPOSE OF TRIP:** Check all that apply

- Business/work     Receive medical care     Provide medical care     Visit family/friends  
 Adoption     Vacation     Non-LDS mission/humanitarian     Other: \_\_\_\_\_

\*\*LDS mission name & MTC location

**\*\*LDS Mission Skip to Section 3: Medical History**

NAME: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 2: ADDITIONAL TRAVEL**

**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: 3-5 star
- Live with locals/private home
- Camping
- Local apartment
- Cruise ship
- Hostels
- Dorm style lodging
- Remote location
- Other: \_\_\_\_\_

**ACTIVITIES:** Check all that apply

- Tour bus
- Ocean/salt water
- Altitude above 8,000 ft (2500 m)
- Animal contact/huntin
- Automobile travel
- Scuba diving
- Sun exposure
- Field work
- Motorcycle/bicycle
- 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
- Risk of blood borne infections
- Air travel/jet lag
- Medical care/evacuation insurance
- Other: \_\_\_\_\_

**SECTION 3: MEDICAL HISTORY**

PERSONAL MEDICAL INFORMATION	Yes	No
Are you sick today (with moderate to severe fever or acute illness)?		
Have you previously traveled to any developing country?		
Did you receive your childhood vaccines?		
Have you ever had chickenpox disease or the vaccine series? If yes, which one: _____		
Are you currently under a physician's care for any health problem?		
Do you smoke?		
Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?		
Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation in the last 3 months?		
Do you have any seizure or brain problems?		
Have you received gamma-globulin or blood transfusions within the past year?		
Have you received any vaccinations or a TB test in the past 4 weeks?		
Have you ever taken anti-malarial medication? If yes, what medication: _____ Did you tolerate it? ____		
Are you, or will you be, at risk for blood borne infections such as HIV, AIDS, or Hepatitis B and C?		
(Females) Are you pregnant or planning on pregnancy? If yes, when: _____		
(Females) Are you currently breastfeeding? If yes, how old is the infant: _____		

**MEDICAL HISTORY**

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

ALLERGIES	Yes	No
Have you ever had a serious or life-threatening allergic reaction?		
Are you allergic to any of the following?		
<input type="checkbox"/> Sulfa <input type="checkbox"/> Neomycin <input type="checkbox"/> Streptomycin <input type="checkbox"/> Polymyxin B <input type="checkbox"/> Eggs or chicken protein <input type="checkbox"/> Baker's Yeast <input type="checkbox"/> Gelatin <input type="checkbox"/> Bee Stings		
Other Allergies: please list _____		

MEDICATION INFORMATION <input type="checkbox"/> <b>NONE</b>			
<i>(Include prescriptions, contraceptives, vitamins, antibiotics, herbal, and over-the-counter)</i>			
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)				Measles, Mumps, Rubella (MMR)			
Chikungunya				Pneumococcal 23			
Cholera				Prevnar 13 / 15 / 20			
COVID-19				Polio IPV/OPV			
Hepatitis A				Rabies			
Hepatitis B Engerix/Heplisav-B				RSV			
**Hepatitis A & B (Twinrix) <input type="checkbox"/> Twinrix <input type="checkbox"/> Accelerated				Tetanus/Diphtheria/Pertussis (Tdap)			
Human Papillomavirus (HPV)				Tetanus/Diphtheria (Td)			
Influenza				Typhoid Oral			
Japanese Encephalitis				Typhoid Injectable			
Meningococcal				Yellow Fever			
MenB				Shingles (Zostavax/Shingrix)			

\*\*Twinrix (0, 1mo, 6mo) OR Accelerated (0, exactly 7d, 21-30d, 12mo)

D/D = Discussed/Declined		Visits	
1 = Not covered by insurance	5 = Will get/has from PCP	V1 = Visit Date:	_____
2 = Pt feels don't need it	6 = Not enough time before travel	V2 = Visit Date:	_____
3 = Personal belief	7 = Will get at destination	V3 = Visit Date:	_____
4 = Side effects	8 = Already has prescription	V4 = Visit Date:	_____

Key: **C = Completed Series**    **Hx dx= History of Disease**    **Hx vax= History of Childhood Vaccination**

**PRESCRIPTIONS**

Weight: \_\_\_\_\_ lbs/Kg

**NO PRESCRIPTIONS GIVEN**

Rx	Dosage	D/D
<b>Acetazolamide (Diamox)</b> <input type="checkbox"/> 250 mg ta <input type="checkbox"/> 2.5 mg/kg po bid = _____mg/cap Take 1/2 to 1 tab/cap bid for prevention of AMS	#	
<b>Atovaquone/Proquanil (Malarone)</b> <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 x7 days after leaving area for prevention of malaria. Take with food. <input type="checkbox"/> Take _____ tablet(s) po qd x3 days for malaria self-treatment <b>Pediatric Dosing: Take with food</b> <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 x7d after leaving area for prevention.		
<b>Azithromycin (Zithromax)</b> <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.		
<b>Cefdinir (Omnicef)</b> <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.		
<b>Chloroquine Phospate (Aralen)</b> <input type="checkbox"/> 500 mg tab <input type="checkbox"/> 8.3 mg/salt kg po q wk = _____mg/cap q wk. Mix 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.		
<b>Ciprofloxacin (Cipro) 500 mg tab</b> Take 1 tab po bid at onset of travelers' diarrhea x 1-3d or until sx resolve.		
<b>Dexamethasone (Decadron) 4 mg tab</b> Take 1 tab po qid until sx improve or pt is down, for tx of AMS.	# 10	
<b>Doxycycline 100 mg tab</b> <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.		

Rx	Dosage	D/D
<b>Doxycycline 100 mg tab (missionaries)</b> (Only missionaries traveling to malaria area/code #4) <input type="checkbox"/> Take 1 tablet po qd starting two days prior to leaving the USA. Take with food.	# 28	
<b>Fluconazole (Diflucan) 150 mg tab</b> Take 1 tab po q wk prn for treatment of yeast infection.		
<b>Levofloxacin (Levaquin) 500 mg tab</b> Take 1 tab po qd at onset of travelers' diarrhea x 1-5d or until sx resolve.		
<b>Mefloquine (Lariam)</b> <input type="checkbox"/> 228 mg base/250 mg salt tab (4.6 mg base/kg = _____ mg/cap) Mix cap w/ food. <input type="checkbox"/> Take _____ tab/dose po once weekly starting 2wk prior to travel to malaria area. Cont. taking x1wk during travel in and x4wk 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.		
<b>Nifedipine 10 mg tab</b> Take 1 tab po initially, then 2 tabs bid for tx of HAPE.	# 10	
<b>Scopolamine Transderm Pk/4 patches</b> Apply to bare skin behind ear to prevent motion sickness. Place 4hrs before need.		
<b>Xifaxan (Rifaximin) 200 mg tab</b> Take 1 tab po tid at onset of travelers' diarrhea x 1-3d or until sx resolve.	# 10	
<b>TMP/SMX (Bactrim)</b> <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.		
<b>Artemether/lumifantrine (Coartmen)</b> 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.		
<b>Graduated compression stockings</b> Wear during long distance travel to prevent DVT/PE.		
<b>Epi</b> <input type="checkbox"/> EPI PEN 0.3 mg <input type="checkbox"/> EPI PEN JR 0.15 mg		

NAME: \_\_\_\_\_ Date: \_\_\_\_\_

**WRITTEN/VERBAL/ELECTRONIC EDUCATION**

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

**REGION SPECIFIC/OTHER EDUCATION**

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

**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:

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Vaccine	Lot #	Dose	Category	Site	Payment Information
					<input type="checkbox"/> Cash _____ <input type="checkbox"/> Card _____
					<input type="checkbox"/> Check # _____ <input type="checkbox"/> Voucher
					RN:
					Date:
					Reviewed by: Dr. Jakrapun Pupaibool, MD/ Theresa Sofarelli, PA-C/ Dr. Daniel Leung, MD
					Date: