Catonsville Travel Vaccines

5707 Calverton St Suite 1B
Catonsville, MD 21228
410-788-2350 Fax 410-788-6859
www.GreatVaccines.com

We provide different types of services for different types of travelers and non-travelers.

A Traveler's Questionnaire is completed. It may be:
1) Completed online and submitted online
2) Downloaded and completed then faxed (410-788-6859) or mailed to our office.

We must have this questionnaire completed and submitted to us in advance of your office visit.

OFFICE CONSULTATIONS

The traveler completes and returns the Travel Questionnaire by mail, fax, or online. The traveler makes an appointment. A personalized consultation report is generated. Vaccines are administered and travel prescriptions are written. The cost is $75.00 plus the vaccine administration fees and the cost of the vaccines. Prescriptions are included. Cash, debit cards, and credit cards are accepted.

VACCINES AND/OR PRESCRIPTIONS ONLY

This is for the traveler who knows exactly which vaccines, or prescriptions, he wants. Travelers who do not know which vaccines or medications they want, or need, should schedule a Travel Consultation We obtain and review a medical questionnaire from the patient. An appointment is then made for the patient to receive the vaccines and prescriptions. We charge an administration fee of $25.00 for the first vaccine, $15.00 for each additional vaccine given, and the cost of the vaccines. If multiple visits are required to complete a vaccine series, an administration fee of $15.00 is charged plus the cost of the vaccines. Vaccines received are recorded in the official WHO Certificate of Immunizations. (The yellow book)The prices above also apply to non-travelers who require immunizations.

At your office visit, prescriptions may be written for malaria, traveler's diarrhea, motion sickness, or altitude sickness. The cost is $25 and covers all medications related to travel.

NOTE: WE DO NOT COMPLETE PRIOR AUTHORIZATIONS FOR MALARIA MEDICATIONS. Most prescription plans will not cover these medications unless the patient actually has malaria. Most travelers will discover that they have to pay out of pocket for malaria medications.

PAYMENT

Payment is required at time of service. We accept cash, credit cards, and debit cards. We do not accept any insurance; however, we do issue a receipt that you may use to submit to your insurance company for reimbursement. Our receipt details the services provided, the appropriate codes, and fees paid. Because a Certified Travel Medicine physician provides our services, many of our clients have received reimbursement for some, or all, of the services provided.

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TRAVEL PATIENT QUESTIONNAIRE

Section I- Patient Info

(PLEASE PRINT CLEARLY)

________________________ ________________________ ____________
Last Name   First Name   Middle Initial

Address____

City______________________ State__________ Zip____________

DOB ______________ AGE __________ SEX M ☐ F ☐ E-Mail Address______________________

PHONE (home)________________(cell)________________ (work)________________

EMPLOYER: ________________________ OCCUPATION: ________________________

REFERRED BY: ☐ **INTERNET SEARCH** ☐ **PHYSICIAN** ☐ **CDC WEBSITE** ☐ **FRIEND /RELATIVE**
(PLEASE CIRCLE)
☐ **OTHER**________________________________

PRIMARY CARE PHYSICIAN ________________________PHONE: ______________

ADDRESSLOCATION: ____________ ________________________________

Section II- Type of Service

☐ **Travel Consultation- Please complete entire Questionnaire**

☐ **Scheduled Appointment**	**$75.00**
☐ **2nd person Consultation**	**$45.00**
☐ **Vaccines (skip Section III if not traveling)**	
☐ **Prescriptions**	**$25.00**
☐ **PPD (Tuberculosis screen)**	**$25.00**

Please read the "Travel Questionnaire and Fees" section on our website.

Last Name_________________________________**First**________________________

SECTION III TRAVEL INFORMATION

PLEASE LIST THE COUNTRIES YOU ARE TRAVELING TO IN ORDER | APPROXIMATE LENGTH OF STAY IN EACH COUNTRY

____ ____________________________________
____ ____________________________________
____ ____________________________________
____ ____________________________________

DEPARTURE DATE__________________________________ RETURN DATE______________________________

REASON FOR TRAVEL ☐ TOURIST ☐ BUSINESS ☐ MISSION ☐ OTHER ______________________________

ACCOMODATIONS ☐ HOTEL ☐ YOUTH HOSTEL ☐ FAMILY/HOME ☐ CRUISE ☐ CAMPING ☐ OTHER ____________________

CHECK ALL THAT APPLY. I PLAN TO :		
Visit rural areas?	☐ Yes	☐ No
Visit only tourist areas	☐ Yes	☐ No
To go hiking or backpacking?	☐ Yes	☐ No
To go bicycling?	☐ Yes	☐ No
To go swimming?	☐ Yes	☐ No
Chlorinated Pool ☐ Fresh Water Lake or Stream ☐ Ocean ☐		
To travel or to climb to high altitudes?	☐ Yes	☐ No
To scuba dive?	☐ Yes	☐ No
To drive a car or motor scooter?	☐ Yes	☐ No

SECTION IV VACCINES AND PRESCRIPTIONS

Vaccines- please list requested vaccines:: ____

____

Medications Requested for ☐ Malaria ☐ Motion Sickness ☐ Traveler's Diarrhea

please list requested medications here: ____

____

Last Name____**First**______________________________

Section V

Medical History

Current Medications

____

____

____

Current or Previous Medical Conditions

____

YES	No	Please check Yes or No for each question . Use spaces for additional information
☐	☐	Any known allergies to medications, etc ? ________________________________
☐	☐	Any adverse reaction to a previous immunization? ________________________________
☐	☐	Any sensitivity/allergy to latex, eggs, insect/bee stings, quinine, or thimerosal (cleaning products or contact lens solution) ? please circle ________________________________
☐	☐	Are you pregnant or suspect that you might be pregnant? ________________________________
☐	☐	Do you have a history of Guillian-Barre Syndrome, seizures, high blood pressure, eczema, motion sickness, or active neurological disorder? Please circle ________________________________
☐	☐	Do you have a chronic mental or physical condition? ________________________________
☐	☐	Do you have a cold, fever, wheezing, or any other acute illness? ________________________________
☐	☐	Do you, or any person you are in close contact with, have immune system problems including HIV/Aids, cancer, or leukemia? Please circle ________________________________
☐	☐	Any history of anxiety or depression?

____

The above information is true and accurate to the best of my knowledge. I understand that I am responsible for all fees. I understand that payment is expected at time of service with cash, debit, or credit card. I acknowledge that I will be given information fact sheets for the vaccine(s) and I will have an opportunity to read the information provided. I understand the benefits and risks of the vaccine(s) will be provided. I agree to ask any questions about the vaccine(s) before they are administered. I request that the vaccine(s) be given to me, or to the minor named above for whom I attest, that I am the child's parent, authorized representative, or legal guardian and may provide effective consent for these vaccine(s).

Relationship to Patient:

☐ **Patient** ☐ **Parent** ☐ **Guardian** ☐**other**___________________________________

Name ***(Please Print)***____

Signature____**Date**____________________________