Tulalip Clinical
PHARMACY

Travel Clinic Screen Form

Date: _____

DEMOGRAPHICS

Name: _____ Phone: _____
Last First MI

Address: _____ City: _____ Zip: _____

DOB: _____ Weight (children under 12) _____ lbs. Gender: ☐ M ☐ F

Race: (please check only one – required for input on the Washington State Immunization Registry website)

☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Pacific Islander ☐ Other

INSURANCE INFORMATION – Tulalip Clinical Pharmacy can attempt to bill your prescription insurance (not medical)

Insurance Name: _____ PCN: _____

BIN: _____ RX Group: _____

ID Number: _____ Person Code: _____

Coverage: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

TRIP INFORMATION

Date of Departure: _____ Date of Return: _____

Itinerary (please list countries in sequence of arrival, including layover flights):

Country/Cruise	Region/City	Duration

MEDICAL INFORMATION

Do you have any allergies to medications, foods, vaccines or insect bites? ☐ No ☐ Yes: _____

Are you currently taking any immunosuppressants? ☐ No ☐ Yes: _____

List any current prescription medications	List any over-the-counter medications

MEDICAL HISTORY QUESTIONNAIRE – failure to disclose history my result in improper treatment

☐ Yes	☐ No	1.	Any illness or medical problems in the past five years needing physician follow-up?
☐ Yes	☐ No	2.	Have you ever been treated for severe depression or psychiatric disorder?
☐ Yes	☐ No	3.	Do you have impaired liver function?
☐ Yes	☐ No	4.	Do you have severe kidney impairment?
☐ Yes	☐ No	5.	Do you have underlying cardiac conduction disturbances or irregular heartbeat?
☐ Yes	☐ No	6.	Have you ever been tested for G6PD deficiency?
☐ Yes	☐ No	7.	Do you take quinine, quinidine, beta blockers, digoxin or any drug that alters cardiac conduction?
☐ Yes	☐ No	8.	Do you have a history of seizures or epilepsy?
☐ Yes	☐ No	9.	Do you take medications to control seizures?
☐ Yes	☐ No	10.	Do you have a history of psoriasis?
☐ Yes	☐ No	11.	Do you have current or past disease of the retina (eye) or changes to your field of vision?
☐ Yes	☐ No	12.	Do you take the medication cimetidine (Tagamet)?
☐ Yes	☐ No	13.	Do you have a history of a reaction to any antibiotic containing sulfa such as (Bactrim, Septra or Cotrim)?
☐ Yes	☐ No	14.	Do you take the medication Lipitor or any other statin drug for high cholesterol?
☐ Yes	☐ No	15.	Do you have Myasthenia Gravis, take Accutane (for acne) or have an allergy to tetracycline drugs?
☐ Yes	☐ No	16.	Do you take tetracycline (for acne), metoclopramide (for nausea), rifampin (TB med), rifabutin (for bacterial infections), indinavir (HIV medication) or theophylline (for lung disease)?
☐ Yes	☐ No	17.	Do you take Coumadin (warfarin) as a blood thinner?
☐ Yes	☐ No	18.	Do you take hydrochlorothiazide (HCTZ), Lasix or other diuretic medication?
☐ Yes	☐ No	19.	Do you take oral contraceptives?
☐ Yes	☐ No	20.	Are you trying to get pregnant during this trip or in the 3 months that will follow completion of antimalarial medication?
☐ Yes	☐ No	21.	Are you pregnant now? If yes, how far along are you? _____
☐ Yes	☐ No	22.	Are you breastfeeding?

FEES

►Consultation fee

• First person	$60 each
• The second (2) through fourth (4) person of the party	$30 each
• Every fifth (5) person of the party	Free

► Vaccine cost — Varies depending on insurance and copay

► Prescription for malaria and/or traveler's diarrhea — Varies depending on insurance and copay

◦ Consultation fee must be paid either at the pharmacy or online using PayPal® at least 24 hours before appointment. See details on http://www.tulalipclinicalpharmacy.com/pharmacy-services/travel-clinic/ .

◦ Referring and referred patients will get $30 off their next Travel Clinic visit.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Primary Care Provider: _____ Phone: _____

*I request and authorize **Tulalip Clinical Pharmacy** to exchange with or release health care information of the person named above with my primary care provider for the sake of care coordination.*

I have the right to cancel this authorization at any time by writing to the Tulalip Clinical Pharmacy Director at 8825 34th Ave. NE, Tulalip, WA 98271.

Please sign:

_____	_____	_____
Client Full Name (print)	Date	Client Signature
_____	_____	_____
Parent or Guardian Full Name (print)	Date	Parent or Guardian Signature

AUTHORIZATION TO ACCOMPANY A CHILD

I, _____ authorize _____ to accompany my child to the Travel Clinic appointment.

Print Form