Tulalip Clinical PHARMACY

TRAVEL CLINIC SCREEN FORM

Please fax completed form to 360-716-3660

Date:________________

Demographics

Traveler:____ Phone (_________)___________________
Last First MI

Address:____City:______________________Zip: _________________

DOB_____/_____/_____ Weight in lbs (for children under 12) _________ Gender:_____M____F

Race: (required for input on the Washington State Immunization Registry website)

____Caucasian ____African American ____Hispanic ____Asian ____American Indian ____Pacific Islander ____Other

Insurance Information - Tulalip Clinical Pharmacy can bill your prescription (not medical) insurance

Insurance Name: ____

Bin#:____ PCN#:____

RX Group#:______________________ ID#:____________________________ Person Code: ___________

Coverage: Self______ Spouse______ Dependent______ Other______

Trip information

Date of departure_____/_____/_____ Date of return_____/____ /______

Itinerary (*please list countries in sequence of arrival and include layovers):

Country/Cruise	Region/City	Duration

Medical Information

Do you have any allergies to medications, foods, vaccines or insect bites? ____No ____Yes:____________________________

Current prescription medications	Over-the-counter medications

Medical History: (failure to disclose history may 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 so, how far along are you? ______________
____Yes ____No 22. Are you breastfeeding?

Authorization to Release Protected Health Information

Primary Care Provider____ Phone ____

I request & 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 understand that signing this form is voluntary. I do not need to sign this form in order to receive healthcare treatment.

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

Unless crossed out, I authorize release of all health information relating to diagnosis, testing or treatment for HIV/AIDS, sexually transmitted disease, psychiatric disorders/mental health, or drug/alcohol abuse.

Please sign:

____ ____

Client Full Name (print) Client Signature Date

____ ____

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

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Authorization to accompany child

I,______________________________ authorize _________________________________ to accompany my child to the travel clinic appointment.