University of Pittsburgh | Vaccination and Health Connection Hub | Health Sciences

University of Pittsburgh | School of Pharmacy

Comprehensive Medication Management Benefit

Pre-Travel Health Consultation Form

Thank you for your interest in our Travel Health Consultation service. We look forward to helping you stay healthy during your upcoming travel.

There are many factors to consider regarding your health when traveling abroad and we are here to help guide you through them. We encourage you to plan as far in advance as possible to ensure all your travel health needs are met.

To help us prepare for your consultation, please complete the Pre-Travel Health Consultation Form below and save a copy of the form to your computer then **upload your completed form to our secure HIPAA compliant** weblink.

Once we have your information, our clinicians will create a comprehensive plan to help you stay healthy while traveling, including a recommended plan for vaccinations, preventative medications, and over-the-counter products. Clinicians will also work with you and your insurance coverage regarding vaccine costs.

The Hub team will reach out to you within two business days to schedule a virtual or in-person consultation with one of our clinicians. At the consultation, we will review your plan and schedule your vaccine appointment(s). Please note, there is an out-of-pocket cost for your travel health consultation appointment.

If you are a Pitt student or employee with UPMC health insurance, you have other travel health consultation options available to you. View these options at https://www.healthhub.pitt.edu/services. If you have questions about your options, please call 412-383-4372 or email HubTravel@pitt.edu.

Tips for Form Completion

- **Gather your medical history including all current medications and dates of all previous vaccinations.**
- Click inside the boxes to enter text.
- All dates should be entered MM/DD/YYYY.
- Confirm the correct spelling of all countries, regions/states, and cities. If needed, do an internet search on the country to obtain accurate information.
- List each country (including airport stops) or unique travel activity location separately and **IN ORDER**! Some travel vaccination recommendations are based upon the order of destinations visited.
- Please call us if you have any questions about this form @ 412-383-4372.

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General Patient Information

Do you have health insurance provided by the University of Pittsburgh for the patient listed on this form? ☐ YES ☐ NO

Please complete the insurance information below or provide images of your cards via email at HubTravel@pitt.edu

Medical insurance:

Policy ID #:

Prescription insurance:

Group #:

Patient Name (exactly as it appears on passport):

Preferred Name/Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them Preferred name

Birthdate: Sex: ☐ Female ☐ Male ☐ I prefer not to disclose

Name of guardian (if applicable)

Preferred Phone: Mobile

Alternate Phone: Mobile

Home Address:

City: State: Zip Code

Email:

Primary Care Physician (or physician who provides most medicine):

Primary Care Physician phone/fax:

Travel Plans

Countries/regions/cities/layovers (in order of visit)	Arrival Date	Departure Date

Check all that apply for the questions on this page:

Reason for travel: ☐ Vacation ☐ Education/research ☐ Adoption ☐ Visit friends/family
☐ Work (urban, office-based, conference) ☐ Work (rural, outdoors, local community) ☐ Obtain medical/dental care)
☐ Mission/volunteer work ☐ Other: _____

Where will you stay? ☐ Resort/large hotel ☐ Small hotel/AirBnB ☐ Cruise ship
☐ Private home (with locals) ☐ Private home (with relatives) ☐ Private home (expatriate or high-end)
☐ Primitive camping ☐ Up-scale camp/lodge ☐ Dormitory/ hostel ☐ Other: _____

What type(s) of areas will you visit?: ☐ rural ☐ urban ☐ remote

Will you climb to high altitudes (8,000 feet/2,438 meters) or higher)?: ☐ Yes ☐ No ☐ Not sure

Will you be exposed to body fluids (example: performing or having medical/dental work)?:
☐ Yes ☐ No ☐ Not sure

Will you be working with animals? ☐ Yes ☐ No ☐ Not sure

Will you have new sexual partners?: ☐ Yes ☐ No ☐ Not sure

Who will you be traveling with?: ☐ Alone ☐ Adult family/friends ☐ Children ☐ Colleagues ☐ Guided Tour

What forms of transportation do you plan to use?:
☐ Public transit (bus, railway, tram) ☐ Private car/truck ☐ Taxi/Uber ☐ Boat
☐ Motorcycle ☐ Small plane/helicopter ☐ Other: _____

Health History (Check all that apply)

Allergies: please describe reaction

- ☐ Antibiotics (example: penicillin, sulfa): _____
- ☐ Other medications: _____
- ☐ Egg
- ☐ Latex
- ☐ Gelatin
- ☐ Yeast
- ☐ Bees/wasps
- ☐ Seasonal
- ☐ Other allergies: _____
- ☐ Side effects or reactions from previous medicine (nausea, dizziness, stomach upset): _____

Cancer/Blood Disorder

- ☐ Blood clotting disorder
- ☐ Cancer
  - Type(s) _____
  - Active or remission: _____
- ☐ History of blood clots ☐ YES ☐ NO
- ☐ Other: _____

Endocrine

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other: _____

Gastrointestinal

- ☐ Crohn's disease or ulcerative colitis
- ☐ Irritable bowel syndrome (IBS)
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Chronic hepatitis
- ☐ Liver cirrhosis or liver failure
- ☐ Other: _____

Heart/Circulation

- ☐ Arrhythmia (heart rhythm problem including atrial fibrillation, heart block)
- ☐ Pacemaker or defibrillator
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other: _____

Immune System

- ☐ Steroids by mouth in past 3 months
- ☐ Immune suppressive medicines or treatments in past 3 months (examples: radiation, cancer chemotherapy drugs)
- ☐ Spleen removed
- ☐ Thymus disease or thymectomy
- ☐ HIV/AIDS
  - T-cell count/date collected: _____
- ☐ Transplant (organ, bone marrow, stem cell)Organ type: _____
- ☐ Other: _____

Kidneys

- ☐ Dialysis
- ☐ Kidney insufficiency
- ☐ Other: _____

Lungs

- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disorder (COPD)
- ☐ Current or history of tuberculosis
- ☐ Other: _____

Musculoskeletal

- ☐ Rheumatoid Arthritis (RA)
- ☐ Psoriatic arthritis
- ☐ Other: _____

Neurologic/Psychiatric

- ☐ Seizures or epilepsy
- ☐ Anxiety /depression
- ☐ History of Guillain-Barré
- ☐ Other: _____

Reproductive Health

Pregnant: ☐ YES ☐ NO

_____ weeks _____ trimester

- ☐ Breastfeeding
- ☐ Planning to become pregnant in next 3 months
- ☐ Other: _____

Skin

- ☐ Psoriasis:
- ☐ Other: _____

Vaccination History

(complete to the best of your ability)

Most recent international travel (when/where):

Have you ever had a negative reaction to a vaccination? ☐ NO ☐ YES, Explain

Have you received the following vaccinations?

Hepatitis A ☐ Yes ☐ No ☐ Not sure **If yes, did you receive 2 doses?** ☐ Yes ☐ No	**MMR (measles, mumps, rubella)** ☐ Yes ☐ No ☐ Not sure **If yes, approximate date:**
Hepatitis B ☐ Yes ☐ No ☐ Not sure **If yes, did you receive 3 doses?** ☐ Yes ☐ No	**Polio** ☐ Yes ☐ No ☐ Not sure **Did you receive this as an adult?** ☐ Yes ☐ No
Influenza (flu) ☐ Yes ☐ No ☐ Not sure **If yes, list approximate date:**	**Tetanus (TD or Tdap)** ☐ Yes ☐ No ☐ Not sure **If yes, list approximate date:**
Japanese Encephalitis ☐ Yes ☐ No ☐ Not sure **If yes, list approximate date:**	**Typhoid** ☐ Yes ☐ No ☐ Not sure **If yes, list approximate date:**
Meningococcal (meningitis) ☐ Yes ☐ No ☐ Not sure **If yes, list approximate date:**	**Yellow Fever** ☐ Yes ☐ No ☐ Not sure **If yes, list approximate date:**
Cholera ☐ Yes ☐ No ☐ Not sure	

Have you had any of the illnesses listed above for which vaccines are available? ☐ YES ☐ NO

- **If yes, which illness and when**?

Medication History

Please list all current medications including over the counter (OTC) products, vitamins/supplements and herbal products below. Include dose and directions for use.

Drug	Dose	Directions for Use
Example: simvastatin	20 mg	1 tablet by mouth in the evening

Additional Information

Please include additional comments, questions or concerns in the space below.

Consent

Refusal Of Recommended Immunizations and Medications

By initialing below I attest that I understand the risks and benefits of the immunizations that were recommended to me by the Travel Consultation Service. I understand that vaccination/immunizations from illness or disease is voluntary. For any reason, if I choose not to accept the recommended immunizations, I do not hold the Travel Consultation Service or any of its personnel accountable for any risks incurred for being unvaccinated and unprotected from potential illness or disease.

Initials: _____ Date: _____

HIPAA Privacy Consent

By initialing below, the above named patient, (or the guardian of the patient), understands that: • Protected health information may be disclosed or used for treatment, payment or health care operations • The Practice has a "Notice of Privacy Practices" document and the patient/guardian has the opportunity to review this notice • The Practice reserves the right to change the Notice of Privacy Practices at any time • The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions • The patient may revoke this Consent in writing at any time and all future disclosures will then cease • The Practice may condition treatment upon the execution of this Consent.

Initials: _____ Date: _____

Consent To Treat

I understand the interactions, allergies, warnings, precautions, and potential adverse reactions regarding the medications and immunizations that I received during the Travel Consultation. I have read the information on the vaccine information statement sheet (VIS from the CDC) and understand the information. I voluntarily consent to receive the medications and/or immunizations. By signing below, I hereby consent to evaluation, testing and treatment for me or the above named patient as directed by the physician or his or her designee during the Travel Consultation. By signing below, I certify I have read and understand and agree to the content on this page including the **HIPAA Privacy Consent, Refusal of Recommended Immunizations, And Consent To Treat.**

Signed: _____ Date: _____

Relationship of the person who signed for the patient: _____

Witness from Travel Clinic: (Print, Sign, Date): _____

_____

Please download this completed form to your computer. Then upload your completed form to our secure HIPAA compliant weblink.

How did you hear about the HUB?

_____

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