

# Catonsville Travel Vaccines

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[www.GreatVaccines.com](http://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 and paid for 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 cost of the vaccines. Prescriptions are included.

## CONSULTATION REPORT BY MAIL or E-MAIL

The traveler completes and returns the Travel Questionnaire by mail, fax, or online. A personalized consultation report is generated and mailed, or E-Mailed, to the traveler. The consultation report includes recommended vaccines, medications, and country specific information. The cost of the consultation report is \$50.00 postage included.

After reviewing the report, the traveler makes an appointment to receive the vaccines they have selected. In addition, the traveler may receive any prescriptions required. The fee for vaccine administration is \$25.00 and the prescription fee is \$25.00.

## VACCINES ONLY

This is for the traveler who knows exactly which vaccines he wants. We charge an administration fee of \$25.00 and the cost of the vaccines. The \$25.00 is a set fee, regardless of the number of vaccines received. If multiple visits are required to complete a vaccine series, the administration fee is charged only for the first visit. Vaccines received are recorded in the official WHO Certificate of Immunizations. Non-travelers follow the same procedures.

## PRESCRIPTIONS ONLY

The traveler completes a medical questionnaire and prescriptions are written. The medical history portion of the Traveler Questionnaire is completed and mailed, faxed, or online. The cost is \$25.00.

## PAYMENT

Payment is required at time of service. We accept cash, checks with proper ID, 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 physician provides our services, many of our clients have received reimbursement for some of the vaccines.



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 <input type="checkbox"/> TOURIST <input type="checkbox"/> BUSINESS <input type="checkbox"/> MISSION <input type="checkbox"/> OTHER _____		
ACCOMODATIONS <input type="checkbox"/> HOTEL <input type="checkbox"/> YOUTH HOSTEL <input type="checkbox"/> FAMILY/HOME <input type="checkbox"/> CRUISE <input type="checkbox"/> CAMPING <input type="checkbox"/> OTHER _____		
CHECK ALL THAT APPLY. I PLAN TO :		
Visit rural areas?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Visit only tourist areas	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To go hiking or backpacking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To go bicycling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To go swimming?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chlorinated Pool <input type="checkbox"/> Fresh Water Lake or Stream <input type="checkbox"/> Ocean <input type="checkbox"/>		
To travel or to climb to high altitudes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To scuba dive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To drive a car or motor scooter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### SECTION IV VACCINES AND PRESCRIPTIONS

**Vaccines-** If you already know what you want please list here: \_\_\_\_\_

\_\_\_\_\_

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

If you already know what you want please list 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  
\_\_\_\_\_  
\_\_\_\_\_

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 check, cash or credit card. I acknowledge that I have been given information fact sheets for the vaccine(s) and I have had an opportunity to read the information provided. I understand the benefits and risks of the vaccine(s). 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). I have received a Notice of Privacy Practices.

**Relationship to Patient:**

Patient  Parent  Guardian  other \_\_\_\_\_

Name *(Please Print)* \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_