We provide different types of services for different types of travelers.

Consultation

The traveler meets with Dr. Williams. The traveler's itinerary and medical questionnaire is reviewed. A personalized consultation report is generated which includes recommended vaccines, recommended medications, and country specific information. Vaccines are administered and travel prescriptions are written. The cost is $75.00 plus vaccine administration fees and the cost of the vaccines. Prescriptions are included with the consultation. For each additional immediate family member, present at the consult, there is an additional charge of $45.00 each.

Consultation Report by Mail or Email

The traveler completes and returns an itinerary for counties to be visited and a medical questionnaire by mail or from our website. After payment is made, a personalized consultation report is generated and mailed, or emailed, to the traveler. The consultation report includes recommended vaccines, recommended medications, and country specific information. The cost of the consultation report is $75.00 with free postage.
After reviewing the report, the traveler makes an appointment to receive the vaccines they have selected. The traveler pays the vaccine administration fees and the cost of the vaccines. Prescriptions are included with the consultation.

Vaccines Only.

This is for the traveler who knows exactly which vaccines he wants. We obtain and review a medical questionnaire from the patient. The traveler pays the administration fees and the cost of the vaccines. The administration fee for the first vaccine is $25.00. The fee for each additional vaccine is $15.00 per vaccine. If multiple visits are required to complete a vaccine series, the additional administration fee of $15.00 is charged for the additional vaccines in the series. Vaccines received are recorded in the official WHO Certificate of Immunizations. (The yellow book)

Prescriptions Only.

The traveler completes a medical questionnaire and prescriptions are written. The cost is $25. Travelers must pick up prescriptions from office and present proper photo identification.

Catonsville Travel Vaccines
5707 Calverton Street Suite 1B
Catonsville, Maryland 21228
Office 410-788-2350 Fax 410-788-6859

TRAVEL PATIENT QUESTIONNAIRE

(PLEASE PRINT CLEARLY)

_____ _____ _____
Last Name First Name Middle Initial

Address_____

City_____ State_____ Zip_____

DOB _____ AGE _____ SEX M ☐ F ☐

PHONE (home)_____(cell)_____ (work)_____

EMPLOYER: _____ OCCUPATION: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN _____ PHONE: _____

ADDRESS LOCATION: _____

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

NAME_____ _____ _____
LAST FIRST MIDDLE INITIAL

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
_____

Immunizations and Diseases
When did you receive your last Tetanus vaccine?_____
When was your last dose of polio vaccine?_____
Have you ever had chickenpox? [ ] yes [ ] no Received the vaccine? [ ] no [ ] yes –when?_____

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**_____