TravelSafe Clinic

PHARMASAVE®
101-2280 East Hastings Street
(Garden Drive), Vancouver, BC

Appt call: **604.251.1975**
info@TravelSafeClinic.ca
www.TravelSafeClinic.ca

CLIENT INTAKE FORM 2

Last Name:	Middle Initial:	First Name:
Canadian Citizen: ☐ Y ☐ N	Sex: ☐ M ☐ F	Personal Health Number:
Date of Birth: Y M D	Age:	Email:
Address:	City/Prov:	Postal Code:
Name of Guardian:	Child's Weight:	Parental Consent (Signature):
Your Tel #:	Emergency Contact (EC) Tel #:	Name of EC:

PLEASE SELECT THE REASON FOR YOUR VISIT TO TRAVELSAFE CLINIC:

OCCUPATIONAL HEALTH: ☐ YES ☐ NO **If YES,** what is the name of your school or employer?

IMMIGRATION: ☐ **HAJJ:** ☐

WAIVER OPTION TO BE SELECTED BY MEDICAL STAFF ONLY **WAIVER:** ☐ YES ☐ NO

CLIENT TO COMPLETE IF APPLICABLE

I _____, have declined a pre-travel consultation for my upcoming trip. I understand there may be health risks associated with travel to my destination including mosquito-borne diseases and food and water safety risks. **Signature**: _____

ALLERGIES: ☐ NKDA ☐ NKA

MEDICATIONS:

Current Medical Conditions:

Immunization History (TO BE COMPLETED BY MEDICAL STAFF ONLY)	**Last Dose**
1. Tetanus / Diptheria	
2. Measles, Mumps & Rubella	
3. Polio	
4. Varicella (Chicken Pox)	
5. Pertussis (Whooping Cough)	
6. Hepatitis A	
7. Hepatitis A / Typhoid (Vivaxim)	
8. Hepatitis B	
9. Hepatitis A / B (Twinrix)	
10. Typhoid ☐ PO ☐ INJ	
11. Meningitis	
12. Yellow fever	
13. Japanese encephalitis	
14. Rabies	
15. Dukoral	
16. Influenza	
17. Pneumococcal	
18. HPV (Gardasil)	
19. Zostavax	
20. Other	

Medical History (TO BE COMPLETED BY CLIENT)	**Yes / No**
1. Fever in last 24 hours?	☐ Y ☐ N
2. Fainted from a vaccine?	☐ Y ☐ N
3. Immune suppression or taking immune suppression med?	☐ Y ☐ N
4. G6PD deficiency?	☐ Y ☐ N
5. History of anxiety or depression?	☐ Y ☐ N
6. Digestive disorders (IBS, Colitis, Crohn's)?	☐ Y ☐ N
7. Pregnant or planning pregnancy?	☐ Y ☐ N
8. Heart disease?	☐ Y ☐ N
9. Diabetes?	☐ Y ☐ N
10. Disorder of liver, spleen or kidney?	☐ Y ☐ N
11. Recent blood transfusion or blood products?	☐ Y ☐ N
12. Thymus disorder?	☐ Y ☐ N
13. Seizures, epilepsy?	☐ Y ☐ N
14. History of Guillain-Barre Syndrome?	☐ Y ☐ N
15. Bleeding disorder?	☐ Y ☐ N
16. Other?	☐ Y ☐ N
HEALTH HISTORY NOTES (For Medical Staff Only):	

Consultant's Initials:

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Client's Name:

Date Stamp 1				**Date Stamp 2**			
Recommended Vaccine	**Dose**	**Lot #**	**Price $**	**Recommended Vaccine**	**Dose**	**Lot #**	**Price $**
☐ Td ☐ TdP ☐ TdaP	☐ 1 ☐ 2 ☐ 3 ☐ B		$	☐ Td ☐ TdP ☐ TdaP	☐ 1 ☐ 2 ☐ 3 ☐ B		$
Polio	☐ 1 ☐ 2 ☐ 3 ☐ B		$	Polio	☐ B		$
MMR	☐ 1 ☐ 2		$	MMR	☐ 1 ☐ 2		$
Varicella	☐ 1 ☐ 2		$	Varicella	☐ 1 ☐ 2		$
Hepatitis A	☐ 1 ☐ 2		$	Hepatitis A	☐ 1 ☐ 2		$
Hepatitis B	☐ 1 ☐ 2 ☐ 3		$	Hepatitis B	☐ 1 ☐ 2 ☐ 3		$
Hepatitis A / B (Twinrix)	☐ 1 ☐ 2 ☐ 3		$	Hepatitis A/B (Twinrix)	☐ 1 ☐ 2 ☐ 3		$
Hepatitis A / Typhoid (Vivaxim)	☐ 1 ☐ 2		$	Hepatitis A/Typhoid (Vivaxim)	☐ 1 ☐ 2		$
Rabies	☐ 1 ☐ 2 ☐ 3		$	Rabies	☐ 1 ☐ 2 ☐ 3		$
Yellow fever	☐ 1 ☐ B		$	Yellow fever	☐ 1 ☐ B		$
Meningitis	☐ 1		$	Meningitis	☐		$
Japanese encephalitis	☐ 1 ☐ 2 ☐ B		$	Japanese encephalitis	☐ 1 ☐ 2 ☐ B		$
Typhoid ☐ PO ☐ INJ	☐		$	Typhoid ☐ PO ☐ INJ	☐		$
Dukoral	☐ 1 ☐ B		$	Dukoral	☐ 1 ☐ B		$
Influenza	☐		$	Influenza	☐		$
Pneumococcal 23	☐ 1		$	Pneumococcal 23	☐ 1		$
Pneumococcal / Prevnar 13	☐ 1		$	Pneumococcal / Prevnar 13	☐ 1		$
Zostavax	☐ 1		$	Zostavax	☐ 1		$
HPV (Gardasil)	☐ 1 ☐ 2 ☐ 3		$	HPV (Gardasil)	☐ 1 ☐ 2 ☐ 3		$
Other			$	Other			$
Consult Fee			$				$
Immunizer's Initials:		**TOTAL $**	**$**	**Immunizer's Initials:**		**TOTAL $**	**$**

TB SECTION – TO BE COMPLETED BY MEDICAL STAFF ONLY						**Lot #**	**Price $**
History of BCG ☐ Yes ☐ No	History of Positive TST ☐ Yes ☐ No		If YES, 939 req given/faxed to TB Control ☐		Country of Origin:		
Date TST Administered:		Time:		RN Signature:			$
Date TST Read:		Time:		RN Signature:			
➔ Result (48-72 hrs later) ☐ Neg ☐ Pos	If Positive: ☐ Swelling ☐ Redness / Induration ☐ Other reaction (describe):					Measurement mm:	
➔ Follow-up: ☐ No further follow-up ☐ Repeat in 2 Weeks ☐ Recommended chest x-ray ☐ 939 requisition given							
2 Step Date TST Administered:		Time:		RN Signature:			$
Date TST Read:		Time:		RN Signature:			
➔ Result (48-72 hrs later) ☐ Neg ☐ Pos	If Positive: ☐ Swelling ☐ Redness / Induration ☐ Other reaction (describe):					Measurement in mm:	
➔ Follow-up: ☐ No further follow-up ☐ Recommended chest x-ray ☐ 939 requisition given							

CLINIC NOTES:	**TOTAL $**	**$**

Lab Work:	☐ HepBsAb | ☐ Hepatitis A | ☐ Varicella | ☐ MMR | ☐ Rabies | ☐ Requisition Given
Vaccine Schedule:	☐ 0, 1, 6 months Hepatitis B Twinrix | ☐ 0, 6 months Hepatitis A
Rapid Schedule:	☐ 0, 7, 21 days, 1 year Hepatitis B Twinrix | ☐ 0, 4+ weeks MMR | ☐ 0, 6 weeks Varicella

Date Stamp 3							
Vaccine	**Dose**	**Lot #**	**Price $**	**Vaccine**	**Dose**	**Lot #**	**Price $**
☐ Td ☐ TdP ☐ TdaP	☐ 1 ☐ 2 ☐ 3 ☐ B		$	Meningitis	☐		$
Polio	☐ B		$	Japanese encephalitis	☐ 1 ☐ 2 ☐ B		$
MMR	☐ 1 ☐ 2		$	Typhoid ☐ PO ☐ INJ	☐		$
Varicella	☐ 1 ☐ 2		$	Dukoral	☐ 1 ☐ B		$
Hepatitis A	☐ 1 ☐ 2		$	Influenza	☐		$
Hepatitis B	☐ 1 ☐ 2 ☐ 3		$	Pneumococcal 23	☐ 1		$
Hepatitis A/B (Twinrix)	☐ 1 ☐ 2 ☐ 3		$	Pneumococcal / Prevnar 13	☐ 1		$
Hepatitis A/Typhoid (Vivaxim)	☐ 1 ☐ 2		$	Zostavax	☐ 1		$
Rabies	☐ 1 ☐ 2 ☐ 3		$	HPV (Gardasil)	☐ 1 ☐ 2 ☐ 3		$
Yellow fever	☐ 1 ☐ B		$	Other			$
Immunizer's Initials:		**TOTAL $**	**$**	**Immunizer's Initials:**		**TOTAL $**	**$**

Date Stamp 4							
Vaccine	**Dose**	**Lot #**	**Price $**	**Vaccine**	**Dose**	**Lot #**	**Price $**
☐ Twinrix ☐ Hepatitis B	☐ 4		$	Other	☐ 4		$
Immunizer's Initials:		**TOTAL $**	**$**	**Immunizer's Initials:**		**TOTAL $**	**$**

CLINIC NOTES: