



New York Center for Travel and Tropical Medicine
110 East 55th Street, 16th Floor
New York, NY 10022
Phone: (212) 734 - 3000

TRAVEL QUESTIONNAIRE

NAME _____ DATE _____

For Internal Use Only

- \$85 Pre-Travel Consult, per trip
 - \$35 International Certificate of Vaccination (ICV)
 - \$35 Phlebotomy (Blood Draw)
 - \$35 Vaccination administration fee
- PRICE PER DOSE
- \$90 Polio (IPV)
 - \$255 Shingrix (series of 2 at \$255 each; **\$510 TOTAL**)
 - \$85 Tetanus/Diphtheria/Pertussis (TDAP)
 - \$95 Typhoid: Typhim Vi
 - \$105 Hepatitis A (series of 2 at \$105 each)
 - \$95 Hepatitis B (series of 3 or 4 at \$95 each)
 - \$155 Hepatitis A&B combination (Twinrix) (series of 3 or 4 at \$155 each)
 - \$195 Yellow Fever
 - \$165 Meningococcal (Menveo)
 - \$335 Rabies (pre-exposure series of 3 doses at \$335 each; **\$1,005 TOTAL**)
 - \$325 Japanese Encephalitis (series of 2 doses at \$325 each; **\$650 TOTAL**)
 - \$210 Pneumococcal (Pneumovax or Prevnar-13)
 - \$75 Influenza, quadrivalent, trivalent or high dose
 - \$285 Vaxchora (Oral cholera vaccine; patients must be fasting for at least one hour prior to administration of Cholera vaccine)

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THIS FEE SCHEDULE AND I WILL BE GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

Signature _____

Patient Information

Referred by _____

I am a returning patient

Name _____
Last First Middle Initial

Address _____
Number, Street Apt #

City State Zip Code

Telephone:

Cell _____ Home _____ Work _____

Email Address _____

Male Female Date of Birth _____ Age _____

Pharmacy Information _____

Emergency Contact _____ Relationship to patient _____

Phone # _____

** If you want a follow-up letter sent to your primary care physician/referring doctor, complete this section**

I do not wish to have a report sent to my physician OR I do not have a physician

Physician's Full Name

First Name Last Name

Address _____
Number, Street Apt/Suite/Floor #

City State Zip Code

Health History

Current Prescriptions, Over-The-Counter Medications and Herbal Supplements

Medication	Reason for use / medical condition

Pertinent Medical and Surgical History

Allergies (check all that apply)

- NONE
- Antibiotics (please specify _____)
- Other medications Eggs
- Latex Gelatin Yeast
- Bees / wasps Seasonal Other _____
- Side effects/ reactions from previous medications (name medications):

Health History (check all that apply)

- I do not have any issues with my health
 - Steroids by mouth within last 3 months Spleen removed
 - Immune suppressive medications or treatments within past year
 - Thymus disease, thymectomy or Myasthenia Gravis Organ, bone marrow, stem cell transplant
 - HIV/AIDS
 - Other (please specify)
-
-

Kidney, Neurologic/psychiatric and OG/GYN Conditions (check all that apply)

- Kidney insufficiency Anxiety / depression Pregnant?
- Seizures or epilepsy History of Guillain-Barre Planning to become pregnant?

Please bring all vaccination records to your appointment

Travel Details

I am not traveling

Purpose of Trip (Check all that apply)

Vacation Education/Research Visit friends or family Volunteer/Relief Work

Work (Urban, office-based) Work (rural, outdoors or in local community) Relocation

Other: _____

Planned Activities: _____

Will you be:

- Visiting areas that are:

Rural

Urban

Primitive or remote

- Ascending to high altitudes (8,000 ft. or higher?) Yes No

- Working with potential exposure to bodily fluids (e.g., medical or dental work?) Yes No

- Work with exposure to animals? Yes No

Accommodations (check all that apply)

Resort / large hotel

Small hotel / guest house

Cruise ship

Private home (with locals)

Private home (with relatives)

Primitive camping

Up-scale camp/lodge

Dormitory/hostel

Other _____

Dates	City and Country	# Days in each location

TRAVEL HEALTH MEDICAL, P.C.
110 East 55th Street, 16th Floor
New York, NY 10022

HIPAA AUTHORIZATION FORM

Patient's Full Name

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
The New York Center for Travel and Tropical Medicine

The following person (or class of persons) may receive disclosure of protected health information about me:

Physician/Individual/Entity name

Address

City, State Zip Code

Phone Number

Fax Number

2. The specific information that should be disclosed is (please give dates of service if possible):

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for _____.
6. This authorization expires on _____, 20____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

Signature of Individual*

(The person about whom the information relates)

OR, if applicable –

Date of Individual's Signature

Date of Birth

**Signature of Guardian* or
Personal Representative of Patient's Estate**

**Date of Guardian's/Personal
Representative's Signature**

**Description of Authority to Act
for the Individual**