

BOWMONT TRAVEL CLINIC

6535 Bowness Road NW, Calgary, Alberta, T3B 0E8 Phone: (403) 247-0787

Please bring to your appointment: Vaccination records (childhood/travel) and travel itinerary

I have attended the clinic before and there are no changes to my address or contact information.

Name: _____		Date: _____	
Address: _____			
City: _____		Province: _____	
Postal Code: _____		Phone: Home: _____	
Work: _____		Cell: _____	
E-Mail: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Birth Date (DD/MM/YYYY): _____		Alberta Healthcare Number: _____	

Please answer the following questions to the best of your ability they will be discussed further during your consult.

Birthplace: _____ **Immunized as a child?** Yes No Unsure
Date of Departure: _____

Countries travelling to		Duration of stay

Activities Planned during Travel:				
<input type="checkbox"/> Rural/remote	<input type="checkbox"/> Diving	<input type="checkbox"/> High Altitude	<input type="checkbox"/> Surfing	<input type="checkbox"/> Camping
<input type="checkbox"/> Urban/city	<input type="checkbox"/> Climbing	<input type="checkbox"/> Snorkeling	<input type="checkbox"/>	<input type="checkbox"/>
I would define my travel as :				
<input type="checkbox"/> Business/Work	<input type="checkbox"/> Cruise/Tour	<input type="checkbox"/> Volunteer/Mission	<input type="checkbox"/> Backpacking	<input type="checkbox"/> Visiting Family

Medical Conditions : None

	Ye s	No		Yes	No
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Recent chemotherapy (last 4 months)	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/Psychiatric Condition	<input type="checkbox"/>	<input type="checkbox"/>	Recent radiation (last 4 months)	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Immunocompromised or immunosuppressed	<input type="checkbox"/>	<input type="checkbox"/>
Lung Condition	<input type="checkbox"/>	<input type="checkbox"/>	Spleen Removed / No spleen	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Organ / Bone marrow transplant	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia/Lymphoma / Recent cancer	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Tract Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or planning to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Other :		
Arrhythmia / Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>			
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			

Have you been vaccinated in the past 4 weeks? (If yes, which vaccine?) Yes No

What prescribed and over the counter medications do you take? :

Drug Allergies? Yes No **If yes, list:** _____

Other Allergies? Yes No **If yes, list:** _____

Anaphylactic Reaction? Yes No **If yes, list:** _____

Have you had an adverse reaction to an anti-malarial? Yes No **If yes, which one?** _____

Please check if you are allergic to : Latex Eggs Chicken Adhesive Bandages

How did you hear of our clinic? _____

For Clinic Use

<p>Consult Fees</p> <p><input type="checkbox"/> Single: \$60</p> <p><input type="checkbox"/> Couple: \$110</p> <p><input type="checkbox"/> Family (up to 4): \$150</p> <p><input type="checkbox"/> Each additional family member: \$35 x #____</p>	<p>Resort Fees <i>Mexico, Caribbean, USA, Western Europe</i></p> <p><input type="checkbox"/> Single: \$45</p> <p><input type="checkbox"/> Couple: \$80</p> <p><input type="checkbox"/> Family (up to 4): \$100</p> <p><input type="checkbox"/> Each additional family member: \$25 x #____</p>
<p>**All family groups must attend the consult together**</p> <p>Pre-travel consultants reserve the right to alter consult fees.</p> <p>Please Note: Summer Sale Consults must be completed by September 15, 2010</p>	

Vaccine Fees - Prices include administration of the vaccine.

	Adult	Child		
<input type="checkbox"/> Hepatitis A**	\$60	\$40	<input type="checkbox"/> Yellow Fever	\$90
<input type="checkbox"/> Hepatitis B***	\$40	\$25	<input type="checkbox"/> Mantoux	\$30
<input type="checkbox"/> Hep A/ Typhoid	\$100		<input type="checkbox"/> MMR	\$55
<input type="checkbox"/> Twinrix ***	\$75	\$45	<input type="checkbox"/> Influenza	\$25
<input type="checkbox"/> Dukoral (2)	\$80		<input type="checkbox"/> Shingles	\$195
<input type="checkbox"/> Typhoid injectable	\$45		<input type="checkbox"/> Meningitis (A,C,Y,W135)	\$155
<input type="checkbox"/> Tetanus/Diphtheria	\$25		<input type="checkbox"/> Japanese Encephalitis **	\$295
<input type="checkbox"/> Tetanus/Diphtheria/Polio	\$70		<input type="checkbox"/> Tick Borne Encephalitis***	\$95
<input type="checkbox"/> Tetanus/Diphtheria/Pertussis	\$45		<input type="checkbox"/> Gardasil***	\$170
<input type="checkbox"/> Polio	\$50		<input type="checkbox"/> Permethrin treated bed net	\$63
<input type="checkbox"/> Rabies ***	\$200		<input type="checkbox"/> Florastor Capsules 10/50	\$15.59/ \$41.59
<p>*Some Vaccines require more than one injection. Prices are per injection</p>				

_____ Reviewed contraindications to live vaccines with patient.

I, _____ consent to receiving the vaccines as documented above.

Signature: _____ Date: _____

_____ I am aware that it is recommended that patients wait for a minimum of 15 minutes prior to departing the clinic after vaccination.