Aspetuck
Health District

Hello,

Thank you for your interest in scheduling a travel visit at the Aspetuck Health District. Your visit will be with Vanessa Hurta, APRN.

Please complete the attached Travel Visit Worksheet. Please send it to our secure fax at 203-221-7199. Once you have sent this back, we will call you to schedule your appointment.

You will also find the office visit and vaccines prices attached. We do not take insurance for visits or vaccines related to travel. Most insurance companies do not reimburse for travel related expenses, but you are free to submit your receipts to them.

Once you have your appointment set up, please send us copies of your available vaccination records (ask your primary care or any other provider you have seen for a list if vaccines you have received in the past if you do not have your records). It is important to know about your routine vaccinations as well as any travel-related vaccines. Otherwise, we may recommend vaccines that are not necessary and costly.

We look forward to our visit and hearing about your trip.

Sincerely,

Aspetuck Health District

ASPETUCK HEALTH DISTRICT TRAVELER HISTORY FORM

Name: _____ DOB: _____

Gender: _____ Home Phone: _____ Mobile Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Can we send a "travel report" to your email with educational information based on your itinerary? _____

Primary care physician: _____ Pharmacy (name and street/town): _____

Does your insurance cover:
Health care overseas? ☐ Yes ☐ No ☐ Not sure
Medical evacuation? ☐ Yes ☐ No ☐ Not sure

Birth country: _____

CT Wiz is CT's immunization registry that stores your vaccine history. If you do not want your vaccines submitted to Ct Wiz, you must send a signed written request to the CT Department of Health. CT Wiz also collects the following information:

Race: _____ Preferred Language: _____ Ethnicity (please circle): Hispanic or non-Hispanic

TRAVEL PLANS (list additional information on back of form if needed):

Purpose of trip (check all that apply)
☐ Vacation ☐ Education/research ☐ Adoption ☐ Visit friends or family ☐ Missionary/volunteer/humanitarian relief
☐ Work (urban, office-based, or conference) ☐ Work (rural, outdoors, or in local community) ☐ To obtain medical or dental care
☐ Other _____

Planned activities (list all): _____

Will you be:
Visiting areas that are:
- Rural/primitive/remote ☐ Yes ☐ No ☐ Not sure
- Urban ☐ Yes ☐ No ☐ Not sure

Ascending to high altitudes (8,000 ft or higher)? ☐ Yes ☐ No ☐ Not sure

Working with potential exposure to body fluids (e.g., medical or dental work)? ☐ Yes ☐ No ☐ Not sure

Working with exposure to animals? ☐ Yes ☐ No ☐ Not sure

Potentially having new sexual partners? ☐ Yes ☐ No ☐ Not sure

Accommodations (check all that apply):

☐ Resort/large hotel ☐ Small hotel/guest house/B&B ☐ Cruise ship ☐ Private home ☐Primitive camping ☐ Up-scale camp/lodge ☐ Dormitory/ hostel

☐ Other _____

Countries and cities in order of visit	Arrival Date	Departure Date

Name	DOB	Date

HEALTH HISTORY (Check all that apply)

Allergies
- ☐ Antibiotics (e.g., penicillin, sulfa) _____
- ☐ Other medications _____
- ☐ Egg or chicken
- ☐ Latex
- ☐ Gelatin
- ☐ Yeast
- ☐ Bees/wasps
- ☐ Seasonal
- ☐ Other _____
- ☐ Side effects/reactions from previous medications (e.g., nausea, dizziness, stomach upset): _____

Cancers/blood disorder
- ☐ Coagulation disorder
- ☐ History of cancer or blood disorder
- ☐ Other _____

Cardiovascular
- ☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
- ☐ Implanted pacemaker or automatic defibrillator
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other _____

GI
- ☐ Crohn's disease or ulcerative colitis
- ☐ IBS
- ☐ GERD
- ☐ Chronic hepatitis
- ☐ Cirrhosis or liver failure
- ☐ Other _____

Immune system
- ☐ Steroids by mouth within last 3 months
- ☐ Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
- ☐ Spleen removed
- ☐ Thymus disease or thymectomy
- ☐ HIV/AIDS
- ☐ Organ, bone marrow, stem cell transplant _____
- ☐ Other _____

Kidneys
- ☐ Dialysis
- ☐ Kidney insufficiency
- ☐ Other _____

Lungs
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Other _____

Musculoskeletal
- ☐ RA
- ☐ Psoriatic arthritis
- ☐ Other _____

Neurologic/psychiatric
- ☐ Seizures or epilepsy
- ☐ Anxiety /depression
- ☐ History of Guillain-Barré
- ☐ Other _____

Skin
- ☐ Psoriasis
- ☐ Other _____

OB/GYN
- ☐ Pregnant: _____ weeks/trimester
- ☐ Breastfeeding
- ☐ Possible pregnancy in next 3 months
- ☐ Other _____

VACCINATION HISTORY
(Please bring all vaccination records to your appointment.)

Have you received the following immunizations?

Hepatitis A	❑ Yes When? _____	❑ No ❑ Not sure
Hepatitis B	❑ Yes When? _____	❑ No ❑ Not sure
Meningococcal	❑ Yes When? _____	❑ No ❑ Not sure
Measles/Mumps/Rubella	❑ Yes When? _____	❑ No ❑ Not sure
Polio	❑ Yes When? _____	❑ No ❑ Not sure
Tetanus	❑ Yes When? _____	❑ No ❑ Not sure
Typhoid	❑ Yes When? _____	❑ No ❑ Not sure
Yellow Fever	❑ Yes When? _____	❑ No ❑ Not sure
Japanese Encephalitis	❑ Yes When? _____	❑ No ❑ Not sure
Influenza	❑ Yes When? _____	❑ No ❑ Not sure

Other _____

Have you ever had an adverse reaction to an immunization? ❑ No ❑ Yes Explain: _____

Name	DOB	Date

CURRENT MEDICATIONS

Prescription medications: List all current prescription medications

Medication	Reason for use/medical condition

Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.

Product	Reason for use/medical condition

QUESTIONS/CONCERNS

Additional questions or concerns about your travel:

Aspetuck
Health District

Travel Health Visit

1. I have made all attempts to gather my vaccination history before the appointment. Family members who may have records, primary care providers (especially for tetanus and hepatitis vaccine information) and CT Wiz have been utilized. Ct Wiz is the state's vaccine registry and can be accessed here: https://ctwiz.dph.ct.gov/ctwiz_public/Application/PublicPortal

2. The Aspetuck Health District has provided me with notice of the office HIPAA Privacy policy, including information disclosures and how to obtain access to information. I have read the HIPAA policy.

3. I acknowledge that my insurance provider may not cover vaccines and my office visit and I am responsible for payment at the time of my visit. If I have questions, I will contact my insurance provider/company.

4. Prior to receiving my vaccines I will read all the given information about immunizations, potential side effects, risks, and ask any questions. If I am pregnant, I am aware that I should not receive some vaccines. I understand I should not become pregnant three (3) months after receiving MMR, Yellow Fever, or chickenpox vaccines. I understand that live vaccines produce a mild infection that provides immunity. I am aware of potential risks in obtaining vaccines.

5. A parent or guardian must be present when a person under 18 is receiving travel-related services.

*I acknowledge that all the above information is correct and complete. I have read the above information and had the opportunity to ask questions.

Name: _____

Signature: _____ Date: _____

Parent/Guardian Name:_____

Signature: _____ Date: _____

180 Bayberry Lane ■ Westport, Connecticut 06880-2855 ■ Tel. 203.227.9571

Aspetuck
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Allergic Reactions Post Travel/Immunizations Clinics

There exists a chance that anyone having received a vaccination may experience a reaction. The Aspetuck Health District is not staffed with medical personnel on a twenty-four hour, seven day/week basis, and is not equipped to handle severe allergic reactions or acute emergencies.

If you experience a severe reaction following a vaccination, you should go to the emergency room or call 911. If you experience a mild reaction, you should call your primary care physician. Refer to your vaccination record and Vaccination Information Sheets if you need to seek care and make provider aware of which vaccines you have received.

After the problem is resolved, call the AHD and notify the clinic staff of the reaction, treatment and outcomes. Please call 203.227.9571, ext 231, to speak with or leave a message for the Immunization and Travel Clinic staff.

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Informed Consent for Videoconference Telemedicine Session(s)

_____

Patient/Client (Last Name, First Name) Date of Birth

I, _____, have been asked to receive health services via telemedicine. I understand that I will be receiving health care through interactive video conferencing equipment.

I understand that my participation in telemedicine is voluntary, and I may refuse to participate or decide to stop participation at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record.

I understand that my privacy and confidentiality will be protected. When I am receiving services via telemedicine, I will be notified as to who is in the room (and/or) at the remote site.

I understand that the health care providers will have access to any relevant medical information about me, including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I understand the healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations – including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

I understand that electronic communication cannot be used for emergencies or time-sensitive matters and should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite tanking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

I have read this document and I hereby consent to participate in receiving health services via telemedicine under the terms described above. I understand this document will become a part of my medical record.

Please check the appropriate box below.

☐ I agree to participate in and receive health services via telemedicine.

☐ I choose Not to participate in or receive health service via telemedicine.

This authorization, if not cancelled, will expire on (date): _____

Date is not to exceed 12 months, event, or condition upon which this authorization expires. If blank, authorization will expire 12 months from the date of signature below

_____

Signature of Patient/Client/Authorized (legal) Representative Date

☐ I have received verbal consent from the Patient/Client above or Authorized (legal) Representative for telemedicine sessions(s)

_____

Signature of Provider and/or Evaluator Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

CANCELLATION/REVOCATION:_____

Signature of Patient/Client/Authorized (Legal) Representative Date