EAST SHORE DISTRICT HEALTH DEPARTMENT
TRAVEL CLINIC
688 East Main Street
Branford CT 06405
Tel (203) 481-4233

Dear Traveler:

Thank you for contacting us at the Travel Clinic, East Shore District Health Department. You have taken the first step to ensure your travel will be safe by contacting us.

In order for us to better help you with your travel, please send us the following: (1) the completed Travel Visit Worksheet (attached) and (2) a copy of your immunization record. Contact your Physician for a list of your immunizations. We need your immunization record to verify that your immunizations are current. Please FAX the questionnaire and your immunization record our secure fax at 203-483-6894. You may also email the information to: Theresa Heier RN at info@esdhd.org. Once we receive your information, we will call you with an appointment.

We have attached a price list for the Travel Consultation and the likely vaccines you will need. We do not accept medical insurance, but your health insurance plan may reimburse you for travel related expenses and immunizations.

We look forward to meeting you and learning more about your travel.

Yours sincerely,

Theresa Heier, RN
Public Health Nurse Supervisor
Email: their@esdhd.org

Richard Young MD MPH
Medical Director
Email: dryoung@esdhd.org

SMART TRAVELER ENROLLMENT PROGRAM

You may wish to enroll in the U.S. Government Department of State "Smart Traveler Enrollment Program".

https://step.state.gov/step/

This is a free service to U.S. citizens traveling abroad to enroll their trip with the nearest U.S. embassy or consulate. You will receive important information from the Embassy about safety conditions in your destination country, helping you make informed decisions about your travel plans. It could be helpful for family and friends to contact you in the event of an emergency.

East Shore District Health Department-Travel Section
688 East Main Street Branford, CT 06405 (203)481-4233

Pre-Travel Health Consultation and History Form

Personal Information: Please complete this section Date:

Traveler's Name:

Date of Birth_____ Male [ ] Female [ ]

Address: _____
_____

Telephone: (home) _____ E-mail: _____
(work) _____ (cell) _____

Occupation:

Country of Birth: Citizenship:

Trip Information:

Date of Departure from home:_____ Return date/length of trip:_____
Have you traveled internationally in the past?[ ] Yes [ ] No Where? _____
Do you intend to travel frequently in the future? [ ] Yes [ ] No [ ] Maybe
Itinerary: Please give ALL countries to be visited, including stopovers, in the order (if possible) to be visited:
1._____
2._____
3._____
4._____
5._____

Destination: Urban [ ] Rural [ ] Remote [ ] At High Altitude [ ] Beach [ ]

Is this a fixed itinerary? Yes [ ] No [ ] Unsure [ ]

Purpose of trip: (check all that apply)

Vacation	[ ]	Medical care	[ ]	Business	[ ]
Education	[ ]	Adoption	[ ]	Volunteer/Humanitarian	[ ]
Visiting Friends and/or Relatives	[ ]			Long-stay traveler	[ ]

Organized tour? Yes [ ] No [ ] Partly [ ]
Explain: _____

Accommodations: Hotel [ ] Hostel [ ] Staying with locals/family/friends [ ]
Rented House/Apt [ ] Camping [ ] Cruise Ship/Boat [ ]

Will you be travelling alone? Yes [ ] No [ ]
If no, Explain _____

Planned Activities: (check all that apply)

Air Travel	[ ]	Biking	[ ]	Hiking	[ ]	Snorkeling [ ]	Swimming [ ]
Rafting	[ ]	Boating	[ ]	Scuba	[ ]	Climbing/Trekking [ ]	
Contact with Animals [ ]		Cave/spelunking [ ]				Public Transport [ ] (bus, train, etc)	
Visiting schools, hospitals or orphanages [ ]				Health Care Worker [ ]		Occupational exposure [ ]	

Other:_____

Have you obtained travel medical evacuation insurance? Yes [ ] No [ ]

Health History:

Health Care Provider: Telephone:

Address:

Do you have any chronic health problems for which you take medication on a regular basis or see a health care provider?
Yes [ ] No [ ]
If yes, please explain:_____

Are you currently under the care of a physician for any health problem: Yes [ ] No [ ] If yes, explain:_____

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Health History, cont'd.:

Do you currently have or have a past history of:

Antidepressant or psychiatric medication use_____ Yes [ ] No [ ]
Depression, anxiety, panic attacks_____ Yes [ ] No [ ]
Psoriasis (skin disease)_____ Yes [ ] No [ ]
Seizures or convulsions_____ Yes [ ] No [ ]
Cardiac conduction defect, have a pacemaker_____ Yes [ ] No [ ]
Heart disease or surgery_____ Yes [ ] No [ ]
Respiratory (lung) disease_____ Yes [ ] No [ ]
Muscle or bone problems_____ Yes [ ] No [ ]
Intestinal problems including heartburn or reflux_____ Yes [ ] No [ ]
Immune disorder (chemotherapy, HIV, bone marrow or organ transplant, rheumatoid arthritis treatment)_____ Yes [ ] No [ ]
Live/work closely with anyone with immune disorder_____ Yes [ ] No [ ]
Thymus gland surgery or disorder (myasthenia gravis, DiGeorge syndrome) ____ Yes [ ] No [ ]
History of altitude illness_____ Yes [ ] No [ ]
Surgery or hospitalization in past 3-5 years_____ Yes [ ] No [ ]
Have you had any transfusions or blood products in the past 5 years?_____ Yes [ ] No [ ]
Have you ever had Hepatitis (liver infection)?_____ Yes [ ] No [ ]
Has your spleen been removed?_____ Yes [ ] No [ ]
Do you drink alcohol regularly?_____ Yes [ ] No [ ]
Do you smoke?_____ Yes [ ] No [ ]
Have you ever had a TB test?_____ Yes [ ] No [ ]
History of tendonitis / Achille's heel rupture_____ Yes [ ] No [ ]
Other medical problem_____ Yes [ ] No [ ]

Please explain any "yes" answers:

_____

_____

Allergies:

Medication(s) Yes [ ] No [ ] If yes, list:_____
Reaction to vaccine Yes [ ] No [ ] If yes, list:_____
Egg or other food allergies Yes [ ] No [ ] If yes, list:_____
Environmental (pollens, dust, hay fever, etc.) Yes [ ] No [ ] If yes, list:_____
Animals Yes [ ] No [ ] If yes, list:_____
Bee stings Yes [ ] No [ ]
Have you ever experienced anaphylaxis (severe allergic reaction)?____ Yes [ ] No [ ]

Medications:

Please list **all** prescribed and over-the-counter medications and supplements you use:

Medication or supplement:	Reason for use:
1	
2	
3	
4	
5	

When was your last dental visit? _____

Women:

When was your last menstrual period?_____ Was it normal? Yes [ ] No [ ]
Are you currently or are you trying to become pregnant? Yes [ ] No [ ]
Any risk of an unplanned pregnancy? Yes [ ] No [ ]
Are you breastfeeding? Yes [ ] No [ ]
What form of contraception do you use? _____

Please tell us any additional information that you believe is important for us to know as you prepare for your current trip:

_____

I have answered this questionnaire fully and to the best of my ability.

Traveler's signature _____ Relationship if minor _____ Date _____

Reviewed by: _____ RN/ NP/ PA/ MD Date_____

East Shore District Health Department
688 East Main Street, Branford, CT 06405
Tel: 203.481.4233 Fax: 203.483.6894

1. The East Shore District Health Department has provided me with the notice of the office HIPPA Privacy Policy, including information disclosures and how to obtain access to information. I have read the HIPPA policy and have been offered a copy.

2. I acknowledge that my insurance provider may not cover the cost of vaccines and my office visit. I am responsible for payment at the time of my visit and can submit forms to my insurance provider/company for payment if allowable.

3. Prior to receiving my vaccines, I will read all given information about the 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 (3) months after receiving MMR (Measles Mumps Rubella), Yellow Fever, or chickenpox vaccines, or travel to certain Zika virus regions. I understand that live vaccines produce a mild infection that provide immunity. I am aware of potential risks in obtaining vaccines.

4. 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: _____

East Shore District Health Department 688 East Main Street Branford, CT 06405 203-481-4233

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Phone: _____

Patient Address: _____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from the East Shore District Health Department

_____ _____

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority (guardian, POA) to sign this form:

_____ _____

Relationship to patient Print Name

Source of Authority: _____

- You can get a list of the disclosures that we have made of your health information except disclosures for purposes of treatment, payment of health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to our Public health Nurse at the address shown at the beginning of this notice.

Our Notice Of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S.Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to our Public health Nurse at the address shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit our Public Health Nurse at the address shown at the beginning of this notice.

East Shore District Health Department 688 East Main Street Branford, CT 06405 203-481-4233

Privacy Practices

Effective date of notice: February 2013: updated August 2016

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule
We respect our legal obligation to keep health information that identifies you private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information
Examples of how we use information for treatment purposes:

- When we set up an appointment for you.
- When we see you for any health reason.
- When the doctor prescribes medication.
- When our staff helps.

We may disclose your health information outside of our office for treatment purposes, for example:

- If we refer you to another doctor or clinic for care or services.
- If we send a prescription to be filled out side of our office.
- When we provide a prescription for medication to a pharmacist.
- If we phone you to let you know about intended care.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for payment purposes. Some examples are:

- When we prepare bills to send to you or your health care plan.

- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims are mailed, faxed, or sent by computer to you or your health care plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for healthcare operations in a number of ways. Health care operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, for the defense of legal matters, to develop business plans.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses and Disclosures without an Authorization

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors, audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim or a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.

- Disclosures relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information.

- You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to our Office Manager at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost if incurred. If you want to ask for confidential communications, send a written request to our Public Health Nurse at the address shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of the request. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to our Public health Nurse at the address shown at the beginning of this notice.
- You can ask us to amend your health information if you find that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from the date of the request. We will send the corrected information to persons who received the incorrect information and others that you specify. If we do not agree, you can write a statement of you position, and we will include it with your health information along with any rebuttal statement that we may write. Once you statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to our Public health Nurse at the address shown at the beginning of this notice.

East Shore District Health Department Travel Clinic

688 East Main Street, Branford, CT 06405
Telephone: (203)481-4233

Travel Consultation Fee: Includes visit with MD, all prescriptions as needed, health guidance and the latest medical advice for your destination.
Single: $100-
Family (2 or more): $150-
RN Administration Fee (no consultation): $20-

VACCINES	# Of Doses in Series	Timing of Doses	Fee per Dose
Hepatitis A (Adult)	2	At least 6 months after 1st Dose	$108/dose
Hepatitis A (Pedi/Adol)	2	1st: 12-23 months 2nd: At least 6 months later	$61-/dose
Hepatitis B (Adult)	3	0, 1 and 6 months from start of series	$88/dose
Hepatitis B (Pediatric)	3	0, 1 and 6 months from start of series	$51-/dose
Japanese Encephalitis (Ixiaro)	2	2nd dose 7 or 28 days after 1st dose. Must complete series **7** days before travel.	$425/dose
Meningococcal ACWY (16 and older)	1	Needs to be administered at least **10** days before travel	$202-
PPD (TB Skin Test)	1 + f/u for test interpretation	F/U visit 48-72 hrs. after placement	$45-
Rabies		2nd dose: Day 7, Booster 3rd Dose within 3 years of 1st rabies vaccine	$453-$504 depending on availability
Tetanus Diphtheria Pertussis-Tdap	1		$68-
Typhoid- Typhim VI	1	Needs to be administered AT LEAST 2 weeks before travel	$194-
Typhoid-Oral-Vivotif	Oral Rx Available	4 pills every other day for a week. Need to complete Rx AT LEAST 1 week before travel and 10 days before starting any Malaria prophylaxis.	
Yellow Fever	1	Needs to be administered AT LEAST **10** days before travel	$287-
Influenza	1		Varies per type administered

** **Prices are subject to change** **