

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.

Immunized as a child? Yes No Country of Birth _____

Family Physician: _____

Country Travelling to:	Date of Trip:	Duration of Stay:

I would define my travel as:				
<input type="checkbox"/> Business/Work	<input type="checkbox"/> Vacation	<input type="checkbox"/> Volunteer/Mission	<input type="checkbox"/> Visiting Family	<input type="checkbox"/> Other

Medical Conditions: None

	Yes	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"/>	Immunosuppressed (leave blank if unknown)	<input type="checkbox"/>	<input type="checkbox"/>
Lung Condition	<input type="checkbox"/>	<input type="checkbox"/>	Spleen Removed / No spleen	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Organ / Bone marrow transplant	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Tract Problems	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia/Lymphoma / Recent cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or planning to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia / Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Other		

What prescribed and over the counter medications do you take?

Allergies (drug/other) Yes No If yes, list: _____

How did you hear of our clinic? _____

Have you been vaccinated in the past 4 weeks? (If yes, which vaccine?)

First Name: _____

FOR CLINIC USE ONLY

<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 Mexico, Caribbean, USA, Western Europe</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>	

- Latex Eggs/Chicken Adhesive Bandages Fainting Immunosuppressed / Latex

Vaccine Fees - Prices include administration of the vaccine.

	Adult	Child		
<input type="checkbox"/> Hepatitis A**	\$75	\$50	<input type="checkbox"/> Shingles – Shingrix **	\$180
<input type="checkbox"/> Hepatitis B***	\$50	\$40	<input type="checkbox"/> Japanese Encephalitis **	\$230
<input type="checkbox"/> Hep A/ Typhoid	\$110		<input type="checkbox"/> Gardasil***	\$200
<input type="checkbox"/> Twinrix ***	\$80	\$50	<input type="checkbox"/> Influenza (Flu) \$25 or FREE depending on AHS availability	
<input type="checkbox"/> Tetanus/Diphtheria	\$35		<input type="checkbox"/> FluMist	\$25
<input type="checkbox"/> Tetanus/Diphtheria/Polio	\$90		<input type="checkbox"/> High Dose Flu	\$80
<input type="checkbox"/> Tetanus/Diphtheria/Pertussis	\$65		<input type="checkbox"/> Florastor Capsules 50	\$45
<input type="checkbox"/> Polio	\$75		<input type="checkbox"/> Typhoid injectable/oral	\$60
<input type="checkbox"/> Tdap+Polio	\$105		<input type="checkbox"/> Yellow Fever (fractioned doses)	\$75 per
<input type="checkbox"/> Prevnar 13	\$150		<input type="checkbox"/> MMR	\$80
<input type="checkbox"/> Meningitis B ** or ***	\$160		<input type="checkbox"/> Shingles - Zostavax	\$200
<input type="checkbox"/> Meningitis ACYW	\$150		<input type="checkbox"/> Dukoral – double/single	\$100/ \$50
<input type="checkbox"/> Chicken Pox - Varicella	\$100		<input type="checkbox"/> Mantoux	\$55
<input type="checkbox"/> Immunization Booklet	\$15		<input type="checkbox"/> Rabies ***	\$220
<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.