Travel Center at UChicago Medicine

Thank you for contacting the Travel Center at UChicago Medicine. We look forward to seeing you. We are located in Duchossois Center for Advanced Medicine (DCAM) 3D for Infectious Disease. Our address is: 5758 South Maryland Ave, Chicago 60637

Travel Center Appointment: To make sure you are ready for your travel, make your appointment with the Travel Center as soon as possible.

If you need to cancel your appointment, let us know at least 48 hours before.

Travel History Form:

- Each person must **complete a travel health history form and return it to us before their appointment. Our services to you begin when we receive this form.**
- Fill in all the information and sign the form before sending.

We must get the form by: _____. You may send it by:

- Email: DCAM3NephID@uchicagomedicine.org (preferred)
- Fax: (773) 753-1095
- Drop it off at our office
- Mail: Allow 2 weeks from date of mailing for delivery to our office.

Immunizations (Vaccines) for Travel:

- Depending on your health and where you are traveling, **you may need immunizations.**
- Our medical team will look at your travel health history before your appointment to know if any vaccines are needed. All immunizations must have a doctor's order.
- Getting your travel health history before your appointment gives us time to get vaccine orders. **If you do not return the forms by the deadline,** you may need to make another appointment for vaccinations.
- Some immunizations must start 8 weeks before travel and have more than 1 dose. Some immunizations cannot be given together, and we will need a follow-up visit.

Vaccine Recommendations:

- You will get information about any immunizations given to you.
- Available immunizations include:
  - Flu
  - Hepatitis A and B
  - Japanese Encephalitis
  - Menevo
  - MRRmm
  - Pneumonia
  - Polio
  - Rabies
  - TD and Pertussis
  - Tetanus Diptheria
  - Typhoidm
  - Varicella

Travel Center Fees

The following information is to help you understand our billing process.

Health Evaluation Before Your Travel: $118 dollars

You will get a bill for your travel health evaluation when we get your Traveler Health History form. This is for all work done to plan your visit. An evaluation includes:

- Travel Health History Questionnaire
- Review of History and Planned Itinerary
- Travel Health Counseling, including printed instructions and information
- Country and Travel Advisory Information from:
    - Centers for Disease Control and Prevention
    - The U. S. State Department
    - The World Health Organization

Group Travel Evaluations $68 dollars (per person)
Includes list above. For individuals traveling to the same place together.
Return Visit After Your Travel $68 dollars

Immunizations (prices may change)

- Immunizations are not included in the consultation fee.
- Current price for vaccine will be stated at the time of service.

Insurance and Payment:

- Travel related immunizations and consults are often **not covered** by insurance.
- **Contact your insurance company if you think the service is covered.** If so, make your travel immunization appointment with your primary care doctor.
- **Services at the Travel Center are self-pay (out of pocket).** We do not bill insurance for our services, provide claim forms, or contact your insurance company.
- Our Travel Center is **not a Medicare provider.**
- **Payment must be made at the time of service** by credit or debit card.
- We do not provide any authorization to pharmacies for prescriptions.

Payment for work on your travel health plan **must be made** even if you do not come to your first visit or have your recommended immunizations.

For questions, call our team at (773) 834-1443.

Signatures

I have read the above, and I understand the statements listed.

Patient Printed Name: _____

Signature _____ Date: _____

Travel Health History Form

Answer all of the questions completely and accurately. Include all copies of all your immunization records. This information is used to plan your travel health recommendations that are prepared as soon as we have the information.

Not answering all questions may delay your recommendations and immunizations. All information is kept private. Print all your answers. Attach other sheets, if needed.

Your Information (Print)

Name:	Age:

Weight: _____ pounds.	Sex:	Date of Birth:

Place of Birth:

Address:

City:	State:	Zip Code:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Have you ever been a patient at our Travel Immunization Centers before? ☐ No ☐ Yes

If yes, Where: _____ When (date): _____

Name of Employer (person or company you work for):

Are you a University of Chicago Medicine (UCM) employee? ☐ No ☐ Yes

If yes, do you have health **Insurance** from UCM? ☐ No ☐ Yes

Travel Plans (in the order of travel)

Departure Date: _____ **Return Date:** _____

Attach printed and detailed plans (cruise line, travel agent and anything more)

Country Name	List cities	Length of Stay	**Any Rural travel** (country side or suburbs of the city)
1.			☐ No ☐ Yes
2.			☐ No ☐ Yes
3.			☐ No ☐ Yes
4.			☐ No ☐ Yes
5.			☐ No ☐ Yes
6.			☐ No ☐ Yes
7.			☐ No ☐ Yes
8.			☐ No ☐ Yes

Travel Health History Form

Accommodations (Places you will stay) Check all that apply

☐ Resort ☐ Cruise Ship ☐ Private Home ☐ Camp ground ☐ Dormitory ☐ Small hotels

☐ Youth Hostel ☐ Other: _____

Purpose of Travel: Check all that apply

☐ Business ☐ Teaching ☐ Biking or Hiking ☐ Volunteer Organization ☐ Diving

☐ Vacation ☐ Safari ☐ Foreign Study ☐ Climbing ☐ Missionary

Other_____

Medical History

Do you have any allergies? (Latex, eggs, fructose intolerance) ☐ No ☐ Yes

If yes, describe the allergy and the reaction you have: _____

_____

Have you ever had any of the following diseases? If yes, give details and dates.	
☐ Measles, ☐ Mumps, or ☐ Rubella (check all that apply)	☐ No ☐ Yes
Chicken Pox or Shingles	☐ No ☐ Yes
Heart Disease	☐ No ☐ Yes
Hepatitis or Liver Disease or impaired liver function	☐ No ☐ Yes
Kidney Disease or kidney function problems	☐ No ☐ Yes
Gastrointestinal problems (ulcer, ulcer active colitis, Crohns)	☐ No ☐ Yes
Respiratory Disease (asthma or other)	☐ No ☐ Yes
Neurological Disorder (including MS)	☐ No ☐ Yes
Seizure Disorder or Epilepsy	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Psychiatric Disorder	☐ No ☐ Yes
HIV or Immune Deficiency	☐ No ☐ Yes
Cancer or Leukemia	☐ No ☐ Yes
Hives	☐ No ☐ Yes
Psoriasis (diagnosed by a physician)	☐ No ☐ Yes
Blood or Plasma Transfusion	☐ No ☐ Yes
Autoimmune problems (rheumatoid arthritis, systemic lupus, erythematosus)	☐ No ☐ Yes
Endocrine Disease (diabetes, hypo or hyperthyroidism)	☐ No ☐ Yes

Travel Health History Form

Current Medications

Are you taking any medications? ☐ No ☐ Yes **If yes**, list all medications you take, the dose and how often (include oral contraceptives and over-the-counter drugs):

Medication	Dose (how much)	How often (When you take it

Immune System

These questions help us know about any possible risk to you or your contacts from getting some immunizations. **Have you ever had any of the following treatments?**

Radiation Therapy: ☐ No ☐ Yes If yes reason: _____

Cancer Chemotherapy: ☐ No ☐ Yes If yes reason: _____

Cortisone, Steroids or other medications that affect the immune system? ☐ No ☐ Yes

If yes: Give reason, doses, kind (pills, injection, inhaler..) dates of how long you had treatment:

Medication Reason	dose	What kind	Dates of treatment

Do you live (or work closely with) anyone who has: AIDS, an AIDS-like condition, a suppressed immune system, or who is having any of the treatments listed above ☐ No ☐ Yes

Have you ever had a bad reaction to any immunization? ☐ No ☐ Yes **If yes explain:**

Past Immunizations

Give month and year of all doses you had. Attach copies of immunization records.

☐ Tetanus: _____
☐ Gamma Globulin: _____
☐ Diphtheria: _____
☐ Pertussis: _____
☐ Measles: _____
☐ Mumps: _____
☐ Rubella: _____
☐ Yellow Fever:_____
☐ Rabies: _____
☐ Cholera: _____
☐ Hepatitis A Vaccine: _____
☐ Hepatitis B Vaccine: _____
☐ Typhoid (Injected): _____
☐ Typhoid (by mouth): _____
☐ Polio series and boosters: _____
☐ Influenza (Flu shot): _____
☐ Pneumococcal (Pneumonia): _____
☐ Meningococcal (Meningitis): _____
☐ Japanese Encephalitis: _____
☐ Varicella (chicken pox): _____
☐ Other_____

Travel Health History Form

Your Doctor's Information

Who is your personal doctor? Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

Other Information

Give any other information you think may help us in planning your travel health recommendations: _____

_____

_____

_____

_____

Your Pharmacy Information

Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone number: _____

Women Only (assigned female at birth)

Are you pregnant or do you think you may be pregnant? ☐ No ☐ Yes

Are you planning a pregnancy in the next six months? ☐ No ☐ Yes

When was your last menstrual period? Date: _____

Signatures

Make sure that you have answered all questions. Forms that are not completely filled in may delay processing.

Sign and return this form to show you want us to plan your travel health recommendations and immunizations. **(Forms not signed will not be processed).**

Printed Name: _____

Signature: _____ Date: _____

Notice of Health Information Practices

This Notice says how your medical information may be used and shared and how you can see this information. A record is made of each UCM visit (health or medical record). It often has your symptoms, exam and test results, diagnosis, treatment and a plan for future care or treatment.

Your Health Information Rights

Your health record is the property of the healthcare provider or the place that put it together.
The information in your health or medical record belongs to you. You have the right to:

- Ask for a restriction on some uses and the sharing of your information
- Get a paper copy of this notice of health information practices
- See and get a copy of your health record
- Ask for something to be added to your health record
- Get a record of who your health information has been shared with
- Ask how your health information was shared in other ways or at other locations
- Remove your permission to use or share health information. Does not include any information that has already been shared

Our Responsibilities, we are required to:
(We have the right to change our practices and to make a new complaint)

- Keep the privacy of your health information
- Provide you with a notice of our legal duties and privacy practices about information we collect and keep about you
- Follow the terms of this notice
- Tell you if we are not able to agree to a restriction you have asked for
- Agree to reasonable requests about sharing information in other ways or at other locations.

Examples of sharing information for Treatment, Payment and Health Operations

For treatment. We provide your doctor, the hospital or other healthcare provider with copies of reports from your medical record that help them treat you.

For payment. Bills may be sent to you or a third-party payer. Bill Information may say who you are, your diagnosis, procedures, and supplies used.

For regular health operations. Professional staff and the quality improvement team may use information in your health record to know the care and outcomes in your case and others like it. This information helps improve the quality effectiveness of our healthcare and service.

Signatures

I was given the UCM Notice of Health Information Practices. Date: _____

Patient Name: _____ Signature: _____

Witness Name: _____ Signature: _____

Patient Personal Representative Name: _____

Signature: _____ Relationship to patient: _____

Patient not able to sign (Reason): _____