

# SYNERGY TRAVEL CLINIC

Unit 229, 501 Bethel Dr., Sherwood Park, Edmonton, Alberta, T8H 0N2 Phone: (780) 416 - 8747

**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.

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

**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 |
|-------------------------|--|------------------|
|                         |  |                  |
|                         |  |                  |
|                         |  |                  |
|                         |  |                  |
|                         |  |                  |

|  |                                      |  |                                      |  |
|--|--------------------------------------|--|--------------------------------------|--|
| <b>Activities Planned during Travel:</b> |                                      |  |                                      |  |
| <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"/>                 |
| <b>I would define my travel as :</b>     |                                      |  |                                      |  |
| <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<br>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"/> | <b>Other :</b>                           |                          |                          |
| 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

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

**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/<br>\$41.59 |
| <b>*Some Vaccines require more than one injection. Prices are per injection</b> |       |       |   |                     |

\_\_\_\_\_ 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.