TEL: (416) 461-2419 http://travelmedicalclinic.com/

PATIENT REGISTRATION

(PLEASE PRINT CLEARLY)

Patient location:	
Queen	
PATH	
Richmond Hill	
Sheppard	
Etobicoke	

STICK LABEL HERE

OTN: Yes ☐ No ☐

OFFICE USE

LAST NAME: _ _ _ _ _ _ _ _ _ FIRST NAME: _ _ _ _ _ _ _ _ _ _ _

OHIP #: VERSION CODE: EXPIRY DATE (D-M-Y): _ _ / _ _ / _ _ _ _

(*The version code is the 2 letters after the OHIP number on the photo card or the letter(s) located on the bottom right hand side of the red & white card. OHIP only covers basic shots and blood work.)

SEX: MALE ☐ FEMALE ☐ AGE: WEIGHT (IF YOU ARE UNDER 18 YEARS OF AGE): ___kg or ___ lbs. Occupation:

DATE OF BIRTH (D-M-Y): _ _ / _ _ / _ _ _ _ MARITAL STATUS: MARRIED ☐ SINGLE ☐ OTHER ☐

ADDRESS: APT#: CITY: POSTAL CODE:

HOME PHONE: CELL: OFFICE: EXT:

CAN WE LEAVE YOU A VOICEMAIL WITH YOUR LAB RESULTS? YES ☐ NO ☐

CAN WE CONTACT YOU BY EMAIL (INCLUDING SENDING YOU RESULTS OF A LAB TEST)? YES ☐ NO ☐

EMAIL ADDRESS:

EMERGENCY CONTACT NAME: PHONE #:

The doctor may prescribe travelers' prescription (i.e. Malaria pills). For your convenience, we can fill the prescription while you are getting vaccinated.

Would you like us to dispense your prescription in our pharmacy?	Yes ☐	No ☐
Do you have private health insurance or health benefits from school or work?	Yes ☐	No ☐
We strongly recommend that you keep track of the vaccines you receive. Would you like to receive an immunization record card ($5.95)?	Yes ☐	No ☐

We will give you the report of your vaccinations to give to your family doctor. I received the report. (Please initial)_________

THIS IS FOR OFFICE USE, DO NOT FILL. PLEASE CONTINUE TO THE NEXT 2 PAGES → → →

	C	I	D		C	I	D		C	I	D		C	I	D		C	I	D		C	I	D
M. DOIDGE, MD	☐	☐	☐	G. LUCZKIW, MD	☐	☐	☐	O.Y. JIMOH, MD	☐	☐	☐	R. DHILLON, NP	☐	☐	☐	S. SHAFIEY, NP	☐	☐	☐	Y. ILYIN, NP	☐	☐	☐
Initials:				Initials:				Initials:				Initials:				Initials:				Initials:			
A. ABDELLATIF, IMG	☐	☐	☐	A. ROSTAMI, RN	☐	☐	☐	T. B. MANUEL, IMG	☐	☐	☐	C. ROPA, IMG	☐	☐	☐	G. ANAND, IMG	☐	☐	☐	S. W.AHMED,I MG	☐	☐	☐
Initials:				Initials:				Initials:				Initials:				Initials:				Initials:			
M. BAROLO, RPN	☐	☐	☐	R. DALAUIDAO, RPN	☐	☐	☐	E. SULITA	☐	☐	☐		☐	☐	☐		☐	☐	☐		☐	☐	☐
Initials:				Initials:				Initials:				Initials:				Initials:				Initials:			

*MD – Medical Doctor *NP – Nurse Practitioner *IMG – International Medical Graduate *RPN – Registered Practical Nurse *C – Consultant *I – Intake *D – Delegated Act by Directive #___________

DATE: ____________________REPORT GIVEN: ___ INITIAL: ___ FAXED: Y___N___ SCAN: Y___ DATE: ____________________REPORT GIVEN: ___ INITIAL: ___ FAXED: Y___N___ SCAN: Y___

DATE: ____________________REPORT GIVEN: ___ INITIAL: ___ FAXED: Y___N___ SCAN: Y___ DATE: ____________________REPORT GIVEN: ___ INITIAL: ___ FAXED: Y___N___ SCAN: Y___

DATE: ____________________REPORT GIVEN: ___ INITIAL: ___ FAXED: Y___N___ SCAN: Y___ DATE: ____________________REPORT GIVEN: ___ INITIAL: ___ FAXED: Y___N___ SCAN: Y___

PREPAID FOR VACCINE: YES ☐ NO ☐ AMOUNT:

PREPAID FOR VACCINE: YES ☐ NO ☐ AMOUNT:

THANK YOU LETTER: YES ☐ NO ☐

VACCINATION RECORD HISTORY

Were you fully vaccinated as a child? YES ☐ NO ☐

Have you had the following routine immunization/vaccines in the last 10 years? Check the (√) appropriate boxes.

	YES	NO	MAYBE			
TETANUS	☐	☐	☐	If Yes, When?		
DIPHTHERIA	☐	☐	☐	If Yes, When?		
POLIO	☐	☐	☐	If Yes, When?		
ADACEL (TD/PERTUSSIS)	☐	☐	☐	If Yes, When?		
HIB	☐	☐	☐	If Yes, When?		

Have you received any of the following travel vaccinations? Check the (√) appropriate boxes.

	YES	NO	MAYBE			
B.C.G (T.B.)	☐	☐	☐	If Yes, When?		
CHICKEN POX	☐	☐	☐	If Yes, When?		
DUKORAL (ORAL)	☐	☐	☐	If Yes, When?		
GARDASIL (HPV)	☐	☐	☐	If Yes, When? DOSE: #1:	#2:	#3:
HEPATITIS A	☐	☐	☐	If Yes, When? DOSE: #1:	#2:	
HEPATITIS B	☐	☐	☐	If Yes, When? DOSE: #1:	#2:	#3:
INFLUENZA (FLU SHOT)	☐	☐	☐	If Yes, When?		
INFLUENZA (H1N1 SWINE FLU)	☐	☐	☐	If Yes, When?		
JAPANESE ENCEPHALITIS	☐	☐	☐	If Yes, When? DOSE: #1:	#2:	
MEASLES, MUMPS, RUBELLA	☐	☐	☐	If Yes, When? DOSE: #1:	#2:	
MENINGOCOCCAL	☐	☐	☐	If Yes, When?		
PNEUMONIA	☐	☐	☐	If Yes, When?		
RABIES	☐	☐	☐	If Yes, When? DOSE: #1:	#2:	#3:
ROTATEQ/ROTARIX	☐	☐	☐	If Yes, When?		
TBE -TICK-BORNE ENCEPHALITIS	☐	☐	☐	If Yes, When?		
TWINRIX (HEP A&B)	☐	☐	☐	If Yes, When? DOSE: #1:	#2:	#3:
TYPHOID	☐	☐	☐	If Yes, When?		
YELLOW FEVER	☐	☐	☐	If Yes, When?		
ZOSTAVAX (SHINGLES)	☐	☐	☐	If Yes, When?		
OTHER VACCINE(S)	☐	☐	☐	If Yes, When?		

MEDICAL HISTORY

Please rate your overall health? (Check only one) Poor ☐ Fair ☐ Good ☐ Excellent ☐ **AGE:**

What country were you born in? If not born in Canada, at what age did you come to Canada?

Allergies: **Eggs**: Yes ☐ No ☐ **Bees**: Yes ☐ No ☐ **Latex**: Yes ☐ No ☐ **Neomycin:** Yes ☐ No ☐ **Gelatin** Yes ☐ No ☐ **Seasonal Allergies:** Yes ☐ No ☐

Have you ever had the Hepatitis disease?	Yes ☐	No ☐	If Yes, what type?
Are you allergic to or have any bad reaction to any drugs, foods or vaccines?	Yes ☐	No ☐	If Yes, please specify:
Have you fainted or felt dizzy after vaccination in the past? If yes, you MUST remain in the clinic for 20 minutes following vaccination(s).	Yes ☐	No ☐	
Are you on any blood thinners, Prednisone, immuno-suppresive or anti-cancer drugs?	Yes ☐	No ☐	If Yes, please specify:
Have you been sick on any past trips?	Yes ☐	No ☐	If Yes, what happened specifically?

Check (√) appropriate boxes, if you suffer from or have experienced any of the following conditions?

☐ Heart disease	☐ Lung disease	☐ Asthma	☐ Ulcerative colitis	☐ Dizziness	☐ Sun allergy
☐ Deafness	☐ Fear of Needles	☐ Insomnia	☐ Kidney disease	☐ High blood pressure	☐ Paranoia
☐ Ear Perforations	☐ Depression	☐ Crohn's	☐ Ulcers	☐ AIDS/HIV	☐ Sun Stroke
☐ Hepatitis A, B or C	☐ Fear of flying	☐ Cancer	☐ Splenectomy	☐ Immunodeficiency	☐ Excessive susceptibility to heat/cold
☐ Motion sickness	☐ Mental illness	☐ Psoriasis	☐ Currently have a fever	☐ Chicken Pox	☐ Recurrent Pneumonia
☐ Seizures/Epilepsy	☐ Mountain sickness	☐ Stroke	☐ Jetlag	☐ Diabetes	☐ Low Blood Pressure
☐ Traveler's thrombosis (clots)	☐ Other:	☐ Are any of the above are currently severe? If so, which ones?_______________________		☐ To my knowledge I am medically stable.	

CURRENT MEDICATION(S):

Have you taken any of the following for malaria prevention? If yes, check the (√) appropriate boxes and state if you experienced any side effects: ☐ Mefloquine ☐ Malarone ☐ Other: ______________________________

THE SECTION INSIDE THIS BOX IS FOR FEMALES ONLY

Are you pregnant?	Yes ☐ No ☐	Are you trying to get pregnant?	Yes ☐ No ☐
Are you/will you be breast feeding?	Yes ☐ No ☐	Have you ever had an abnormal Pap Test result?	Yes ☐ No ☐

TRAVEL ITINERARY

DEPARTING (D-M-Y): __/__/____ RETURNING: __/__/____

List the countries you plan to visit from first to last:

NAME OF COUNTRY	AREA OR CITY	LENGTH OF YOUR STAY

Purpose of your trip: Business ☐ Pleasure ☐ Both ☐

Do you anticipate being exposed to any of these risks on your trip?

☐ Extreme heat	☐ Physical exertion	☐ Swimming	☐ Poor water	☐ Poor sanitation
☐ Extreme cold	☐ High stress	☐ Diving	☐ Motorcycles	☐ Poor diet
☐ Extreme stress	☐ High altitude	☐ Trekking or Climbing	☐ Risk of sexually transmitted disease	

Please specify the type(s) of trip you are engaging in?

☐ Staying with family/Relatives	☐ Missionary or voluntary work	☐ Developmental work
☐ Affluent Travel in a quality hotel	☐ Travel in rural or remote areas	☐ Air BnB
☐ Business travel in an urban area	☐ Backpacking or trekking in mountains/jungles	

As a courtesy to you, we will send a report of your vaccinations to your family doctor.

YOUR FAMILY DOCTOR: LASTNAME:	FIRST NAME:
ADDRESS:	PHONE #:

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that this visit and the vaccinations are not covered by OHIP. I am aware that the consultation fee is $69.90 per person. Families of 4 or more that come for their appointment at the same time are eligible for consultation at $50.00 per person. The follow up visit fee regarding the same trip and /or booster shots is $25.00 plus the cost of the vaccines. Please note that the discounts do not apply to high risk visits. All prices are subject to change without notice. I understand that you accept all credit cards and interac but not cheques. I agree to stay seated in the lobby for observation for 20 minutes after vaccination of all vaccines. I declare that all information provided on this form is accurate to the best of my knowledge and that any inaccurate information may be detrimental. I consent to be treated by any of the following people: Ontario (College of Physicians and Surgeons fo Ontario - CPSO) Physician, International Medical Graduate (IMG – not licensed by the CPSO), Nurse Practitioner(NP), a Registered Nurse (RN), Registered Practical Nurse (RPN) or a Medical Assistant.

SIGNATURE OF PATIENT OR GUARDIAN:	DATE:

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CONSENT & ROLE EXPLAINED ☐: INITIALS _______	HCP INITIALS:
SOURCE: EPOCRATES ☐ MEDSCAPE ☐ RX ☐	NOTES:
MEDICATION INTERACTIONS CHECKED: YES ☐	
CONTRAINDICATIONS CHECKED: YES ☐	