

International Travel Worksheet

POPULATION HEALTH UNIT



Name:	Gender: M () F ()	DOB: ____ / ____ / ____ Mo Day Yr	Age:	HSN:
Address:	Phone: Home _____ Work _____		Occupation:	Family MD:
Health Centre:		Public Health Nurse:		

HEALTH SCREENING

Breast feeding? () Y () N	Pregnant or possibly becoming pregnant while away? () Y () N		
Do you have any of the following now or in the past? () Immune disorder eg. cancer, leukemia, HIV, other () low platelet count or a clotting disorder () seizure, epilepsy, brain infection, neurologic condition () psychiatric problems, depression () problems with strange dreams, nightmares, or insomnia () stomach or bowel condition, diarrhea or constipation () hepatitis or yellow jaundice () psoriasis Other: _____	Comments:	Are you or will you be taking: <ul style="list-style-type: none"> • medication for heart problems (list) • steroids, prednisone, cortisone (dose) • antibiotics (type) • Pepto-Bismol®, antacids • oral contraceptives • medication for emotional problems Specify: _____	

ALLERGIES

ARE YOU ALLERGIC TO: () any medication? _____ () antibiotics - Amphotocerin B, Penicillin, sulpha, streptomycin, neomycin, kanamycin, gentamycin, polymycin () mercury or thimerosal () yeast or gelatin () eggs () bee stings or a history of hives () other: _____
HAVE YOU EVER HAD A REACTION TO AN IMMUNIZATION? () Yes () No If yes, please describe: _____

INFORMATION NEEDED FOR MALARIA PREVENTION RECOMMENDATIONS

Client's Weight _____
Have you taken antimalarials before? If yes, what was taken? Describe side effects if there were any:
Did you take the malaria medication for the recommended time? () Y () N If no, why did you stop? _____

ITINERARY

Name of client: _____

Departure date:	Return date:	Duration:	
Purpose of travel <input type="checkbox"/> Vacation <input type="checkbox"/> Visit Family <input type="checkbox"/> School <input type="checkbox"/> Volunteer work <input type="checkbox"/> Work Description:	Type of travel <input type="checkbox"/> rural <input type="checkbox"/> urban <input type="checkbox"/> resort <input type="checkbox"/> guided tour <input type="checkbox"/> independent travel fixed itinerary <input type="checkbox"/> independent travel, flexible itinerary Additional Comments:	Meals <input type="checkbox"/> resort / hotel <input type="checkbox"/> eating with family <input type="checkbox"/> adventurous <input type="checkbox"/> preparing own Other:	Activities <input type="checkbox"/> climbing <input type="checkbox"/> diving <input type="checkbox"/> trekking <input type="checkbox"/> camping <input type="checkbox"/> sight-seeing <input type="checkbox"/> health care Other:

DESTINATIONS(Attach copy of itinerary if possible)

Accommodation Codes: A - Hotel B – Cruise ship C - Work compound D - Private home E - Campus F - Hostel G - Safari H - Camp I - Rented foreign home					
	Country and State/Province	City and resort	Date of Entry	Duration	Accommodation Code
1					
2					
3					
4					

**IMMUNIZATION RECORD/
RECOMMENDATIONS**

Name of client: _____

Copy of PANORAMA
Attached _____

Vaccine	Dates previously given	Recommended by MHO ✓	Vaccine	Dates previously given	Recommended by MHO ✓
Cholera			Polio		
Hepatitis A			Rabies		
Hepatitis B			Tetanus/Diphtheria		
Influenza			Typhoid (oral or inj.)		
Japanese Encephalitis			Yellow Fever		
Mantoux			Other:		
Measles/Rubella					
Meningococcal					

TRAVEL ADVICE INFORMATION

Topic	Recommended by MHO ✓	Nursing Actions D = discussed S = Sheet given	Topic	Recommended by MHO ✓	Nursing Actions D = discussed S = Sheet given
Basic preventive measures			Sun and heat		
Food and water precautions			Dengue		
Travel safety			Malaria		
Sexual health			Rabies and animal bites		
Insect precautions			Vaccine information sheets		
Blood-borne diseases					

Medical Health Officer's/PHN's NOTES:

Date: _____ PHN: _____ Medical Health Officer _____ Date _____
(Use back of this form for more space)

<p>Office use only: Date completed referral received: _____ Date Recommendations received by MHO: _____ Date Booked for Appointment: _____ Date Seen: _____</p>
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