Delaware Valley I.D. Associates
Infectious Diseases & Travel Medicine
www.delvalid.com

100 E. Lancaster Avenue
Lankenau MOB East 467
Wynnewood, PA 19096
TEL 610-896-0210
FAX 610-896-5101

Mark J. Ingerman, MD
Bevin L. Dolan, MD
Shilpa B. Rao, MD

Lawrence L. Livornese Jr., MD
Fredy Chaparro, MD
Jackeline Iacovella, MD
Jerome Santoro, MD, Emeritus

Brett C. Gilbert, DO
Mitchell P. Sternlieb, MD
Julia A. Wilhelm, CRNP

TRAVEL APPOINTMENT CHECKLIST

_____ ITINERARY
Please provide your itinerary with the towns/cities you will be visiting and the length of stay in each area. Please be prepared to provide as much detail regarding the types of accommodations as possible.

_____ VACCINATIONS / CURRENT MEDICATIONS
Please provide a list of recent vaccinations and current medications, including over-the-counter, as well as, prescription medications.

_____TRAVEL HEALTH QUESTIONNAIRE
Please have the 8 page questionnaire completed prior to arriving to our office. Please be certain to write your name and date of birth at the top of every page.

_____PAYMENT
Many health insurances DO NOT cover travel visits or vaccinations necessary for travel. Please be prepared to pay for your visit and/or vaccinations at the time of service. We accept cash, check, and credit card.
*Vaccinations will not be administered without payment.

If you are unable to keep your scheduled appointment, please notify our office at least 48 hours prior to your appointment.

We look forward to seeing you.

Directions to our suite – MOB East 467

-Enter the Lankenau Medical Center Campus from Lancaster Avenue.
-Follow the driveway to – Visitor Parking – Garage B to park
-Once parked, take the elevator to G (ground level)
-Exit elevator and go LEFT through the double doors and up the ramp
-Proceed through the next set of double doors into the Atrium walkway
-Make a LEFT past the Atrium Café. This will lead you into the EAST Medical Building
-Take the elevator to the 4th floor – follow the hall to the right to Suite 467

Delaware Valley ID Associates
PATIENT REGISTRATION FORM

Patient Last Name:_____ First: _____ Middle Init:_____

Date of Birth: _____ Gender: _____ Email:_____

Address:_____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

May we leave a message regarding confidential information pertaining to your health status and/or test results on your…

Home Phone? Y or N Cell Phone?: Y or N Work Phone?: Y or N

Do you have a living will? Y or N

Race: White African American Hispanic Asian American Indian Native Hawaiian Other _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other _____

Is your preferred language ENGLISH? Y or N If no, please indicate preferred language: _____

EMERGENCY CONTACT(S)

1. Name:_____ Relationship: _____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

May we share your personal health information with this emergency contact? Y or N

2. Name:_____ Relationship: _____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

May we share your personal health information with this emergency contact? Y or N

FAMILY PHYSICIAN: _____ Phone#_____

REFERRING PHYSICIAN: _____ Phone#_____

LOCAL PHARMACY:_____ Phone#_____

Address, City, State: _____

MAIL ORDER PHARMACY:_____ Phone #: _____

Address, City, State: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand and agree that Delaware Valley I.D. Associates, P.C. and its employees and agents may use and disclose protected health information about me for payment, treatment and/or health care options.

I request that payment of authorized insurance benefits be made either to me or on my behalf to Delaware Valley I.D. Associates, P.C. for any services furnished to me by Delaware Valley I.D. Associates, P.C. and its employees and agents. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient or Guardian Signature Date

Name_____ **DOB**_____

PLANS:

Estimated departure date:_____ Estimated return date: _____ Duration of travel: _____

Please check all that apply:

____ Sightseeing
____ Camping, rural, labor (agriculture, forestry)
____ Visiting family
____ Urban Business
____ Medicine or public health
____ Other_____

ITINERARY:

COUNTRY and ACCOMMODATIONS List the countries you will visit in order of travel and indicate next to each country the type of living conditions: P = primitive S = standard

1._____ _____
2._____ _____
3._____ _____
4. ._____ _____
5. ._____ _____
6. ._____ _____

INTERNATIONAL TRAVEL MEDICAL QUESTIONNAIRE	**YES**	**NO**
1. Do you have any medical condition that warrants maintenance medications or physician follow-up?	_____	_____
2. Do you have a medical condition that is stable now, but that may recur while traveling?	_____	_____
3. Have you had a fever in the past 48 hours?	_____	_____
4. Are you pregnant or might you become pregnant on this trip?	_____	_____
5. Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?	_____	_____
6. Do you have severe thrombocytopenia (low platelet count) or a bleeding disorder?	_____	_____
7. Have you ever had a convulsion, seizure, or epilepsy?	_____	_____
8. Do you have any stomach conditions?	_____	_____
9. Do you have bowel conditions such as diarrhea or constipation?	_____	_____
10. Have you ever had hepatitis or yellow jaundice?	_____	_____
11. Do you have a history of psychiatric problems?	_____	_____
12. Do you have a problem with strange dreams and/or nightmares?	_____	_____

Name_____**DOB**_____

13. Do you have insomnia? _____ _____
14. Do you have psoriasis? _____ _____
15. Do you have any eye conditions? _____ _____
16. Are you prone to motion sickness? _____ _____
17. Do you or any member of your household receive any immunosuppressive drugs (steroids, cortisone, anti-cancer treatment)? _____ _____
18. Have you ever had a skin test for tuberculosis? _____ _____
19. Have you ever fainted from having your blood drawn or from an injection? _____ _____
20. Have you ever developed a fever after receiving a vaccination? _____ _____
21. Have you ever had any bad reactions or side effects from any vaccinations? _____ _____

CURRENT MEDICATIONS

	Medication	Dosage and Frequency
1.		
2.		
3.		
4.		
5.		

MEDICATION QUESTIONNAIRE **YES** **NO**

Are you taking or do you have a prescription for:

1. conduction defect or arrhythmia? _____ _____
2. quinine, quinidine, or medications for a cardiac conduction defect? _____ _____
3. chloroquine or mefloquine to prevent malaria? _____ _____
4. steroids, prednisone, or cortisone? _____ _____
5. antibiotics? _____ _____

Name_____**DOB**_____

6. Pepto-Bismol to prevent travelers' diarrhea? _____ _____
7. antacids? _____ _____
8. oral contraceptives? _____ _____
9. aspirin therapy? (children and adolescent) _____ _____
10. medications for emotional problems? _____ _____
11. medications for seizures, convulsions, epilepsy? _____ _____

ALLERGIES

Are you allergic to:	**YES**	**NO**
any medications? If yes, please list _____ _____	_____	_____
penicillin?	_____	_____
sulfa?	_____	_____
mercury or thimerosal?	_____	_____
gentamicin?	_____	_____
cipro or levaquin?	_____	_____
neomycin?	_____	_____
polymyxin?	_____	_____
streptomycin?	_____	_____
sulfites?	_____	_____
aluminum or aluminum hydroxide?	_____	_____
2-phenoxyethanol?	_____	_____
bee stings, or have a history of hives or urticaria?	_____	_____
yeast?	_____	_____
eggs?	_____	_____

Name_____DOB_____

Are you hypersensitive to gelatin? _____ _____

Are you hypersensitive for beef protein, soy, casein, phenol, or formaldehyde? _____ _____

Other health problems or illness NOT listed above? _____ _____
If yes, please explain below:

_____

_____

_____

_____

_____

_____

Name_____ **DOB**_____

INFORMED CONSENT (To be signed at the time of your visit)

I have been informed of the possible reactions to these inoculations and any medicines prescribed for travel. I have had the opportunity to ask questions about these inoculations of medications. I understand the benefits and risks involved, and hereby request that the above referenced immunizations be administered to me.

I understand that these immunizations will not necessarily provide protection against the diseases they are intended to prevent.

I understand that when vaccines commonly associated with side effects are given simultaneously, the side effects could be accentuated. I understand that severe sensitivity to materials used in production of vaccines such as chicken or duck eggs precludes administration. Similarly, diseases associated with altered immunity such as certain cancers and treatment, which alter the immune status; such as steroids, cancer chemotherapy or radiation, HIV disease, may also preclude vaccination. Finally, pregnancy usually precludes vaccination with live virus vaccines.

Additionally, the side effects of prescriptions and samples, which I have been given, have been discussed with me.

NAME	SIGNATURE	DATE
WITNESS	SIGNATURE	DATE

LIVE VACCINE CONSENT (Pregnancy) (To be signed at the time of your visit – if applicable)

I am receiving a live vaccine. I am not pregnant and I agree to prevent pregnancy for the next three (3) months.

NAME	SIGNATURE	DATE
WITNESS	SIGNATURE	DATE

Name_____ **DOB**_____ **TEMP**_____

THIS SIDE TO BE FILLED OUT BY TRAVELER
Indicate to the best of your knowledge with a YES or NO answer. Include date.

THIS SIDE TO BE FILLED OUT BY PHYSICIAN'S OFFICE.

ROUTINE IMMUNIZATIONS

	YES	NO	DATE	ORDERED	DATE	DATE	DATE
Diphtheria-Tetanus Td							
Diphtheria-Pertussis-Tetanus Tdap							
Hepatitis B							
Influenza							
MMR							
Polio: Injectable (IPV)							
Primary Series							
Last Booster							
Pneumovax							
Varicella							
PPD							

REGULATED IMMUNIZATIONS

	YES	NO	DATE	ORDERED	DATE	DATE	DATE
Yellow Fever							

RECOMMENDED IMMUNIZATIONS

	YES	NO	DATE	ORDERED	DATE	DATE	DATE
Hepatitis A							
Twinrix (Hep A/B)							
Immune Globulin							
Meningococcal:							
Menomune							
Menactra							
Typhoid Oral							
Typhoid Injectable							
Rabies Pre-Exposure							
Rabies Post Exposure							
Japanese Encephalitis							
Malaria Prophylaxis							

Name_____ **DOB**_____

MALARIA PROPHYLAXIS

BUG REPELLENT WITH 30% DEET - Read and follow all directions and precautions on this product label.
PLAQUENIL OR CHLOROQUINE - Take_____tablet(s) once a week beginning one week prior to departure, weekly while in the endemic country(s), and for four weeks after leaving the endemic country(s).
DOXYCYCLINE – Take one tablet daily beginning two days prior to departure, daily while in the endemic country(s) and daily for four weeks upon leaving the endemic country(s).
MEFLOQUINE (LARIAM) – Take one tablet weekly, starting one week prior to departure. Continue taking one weekly during travel in the endemic country(s) and one weekly for four weeks after leaving the endemic country(s).
ATOVAQUONE/PROGUANIL HCL (MALARONE) – Take one tablet daily beginning two days prior to departure, daily while in the endemic country(s) and daily for seven days upon leaving the endemic country(s).

***SEEK IMMEDIATE MEDICAL ATTENTION IF YOU GET HIGH FEVER, SHAKING CHILLS, AND/OR PROSTRATION**.

INFORMATION REGARDING TRAVELERS' DIARRHEA

You may be able to prevent diarrhea by using two chewable Pepto-Bismol tablets four times a day. Do not use if you are taking Doxycycline.
Use_____, tablet(s)_____times daily for three days if you develop severe diarrhea. See physician if not better in 24-48 hours. You may use Imodium AD only if diarrhea is restricting activities. If diarrhea is severe, bloody, or accompanied by fever, contact a doctor.

INFORMATION REGARDING ALTITUDE SICKNESS

Use Acetazolamide (Diamox), _____ tablet(s) _____ times daily beginning 24 hours before ascent, continuing during ascent, and for 48 hours after arrival at high altitude.

INFORMATION I HAVE RECEIVED INCLUDES

Advice To Travelers handout
Vaccine specific advisory sheets for each vaccine I have opted to receive (VIS)

***IF YOU WERE GIVEN ORAL TYPHOID VACCINE, IT MUST BE KEPT REFRIGERATED AND TAKEN EXACTLY AS DIRECTED.**

NOTES:_____

_____

_____ _____
Patient's Signature Date Providers' Signature Date

_____
Patient's Name (please print)

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. ePrescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. The ePrescribe Program includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

By signing this consent form you are agreeing that Delaware Valley ID Associates may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Delaware Valley ID Associates to enroll me in the ePrescribe Program.

_____ _____

Print Patient Name Date of birth

_____

Signature of Patient (or Guardian)