NorthShore
University HealthSystem

Travel Center

2150 Pfingsten Road Suite 3000
Glenview, IL 60026
847-657-5670 fax 847-657-1759

Dear Traveler:

Thank you for contacting the NorthShore Travel Center. We are located within the Glenbrook Hospital campus **Medical Office Building – North, Suite 3000**. Enclosed is a brief description of our services along with a Travel History Form. Please complete the form according to the instructions and return it to us by fax 847-657-1759, **emailed to Travel_Center@northshore.org (preferred)**, or drop it off at our office. If you need to return the forms by mail, please allow 2 weeks from date of mailing for delivery to our office. A separate form is required for each individual traveler. Please be sure the forms are completed and signed before returning them. Incomplete forms may delay processing.

All travelers' health histories must be reviewed by our clinical personnel *prior* to your appointment. All immunizations require physician orders. We ask that you return your paperwork by the deadline specified when you made your appointment. This will allow enough time for your history to be reviewed. Also, it will allow our physicians time to place the vaccination orders. Failure to return forms by the deadline may result in having to schedule an additional appointment for vaccination administration.

We make every effort to accommodate your schedule. Proper travel immunizations may require up to 8 weeks in some cases because some immunizations must be given in a series. So please, plan as far in advance as possible. We ask that you please be respectful of the time scheduled for you and if you must cancel please let us know as soon as possible or at least 48 hours in advance.

Because the Travel Center is a self pay (out of pocket) clinic, ***payment is required at the time of service*** and can be made by credit card, cash or check. Self pay travel center means the services are provided as an out of pocket expense to you. We are not equipped to handle any type of insurance correspondence. We do not bill insurance, we do not issue claim forms, and we do not contact insurance carriers for pre-certifications or authorizations of any kind. **The NorthShore Travel Center is not a Medicare provider**. Please keep in mind insurance does not generally reimburse for travel related immunizations or consults. *If you feel the service is covered by insurance, we suggest that you schedule your travel immunizations through your primary care physician.*

If you have any questions, please call us at (847) 657-5670. We look forward to seeing you at the NorthShore University HealthSystem Travel Center.

Sincerely,

Kathleen Freemon, RN, COHN
Julia Jackson MA/PSA Travel Concierge

Travel Health and Immunization Services Fee Schedule

Initial Travel Health Consultation $49.00**

Patient receives:

- Travel Health History Questionnaire
- Review of History and Planned Itinerary
- Travel Health Counseling, including:
  - Printed instructions and information
- Country and Travel Advisory Information as indicated by:
  - Centers for Disease Control and Prevention
  - The U. S. State Department
  - The World Health Organization
- Vaccination *recommendations*
  - Appropriate documentation of received immunization

** Because some immunizations must be given as a series, and certain immunizations cannot be given together, one or more follow-up visits may be needed.

Immunizations ..... Variable

- Immunizations are *not included* in the consultation fee.
- Vaccine costs fluctuate due to market conditions.
- Current fee for vaccine will be stated at the time of service.

Please Note:

***Your bill will be generated based upon receipt of your Traveler Health History and request for services. Because much of our service involves individualized preparation specifically for your visit, payment for the preparation of your travel health plan will be expected even if you do not come in for the initial visit or receive the immunizations.**

Payment is requested at the time of service by credit card, cash or check.

Prices are subject to change.

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TRAVEL HEALTH HISTORY

Please be sure to answer all of the questions presented below as completely and accurately as possible and include all copies of all available immunization records. This information will be used in planning your travel health recommendations which will be prepared as soon as the information is received. An *incomplete* questionnaire may *delay* your recommendations and immunizations. All information is strictly confidential. Please print clearly. Attach additional sheets, if necessary.

Name_____Age_____Sex_____
Address_____
City_____ State _____Zip_____
Home Phone_____ Cell Phone _____
Date of Birth_____ Place of Birth_____
Weight (approximate)_____lbs.
Marital Status: Please circle Single Married Widowed Divorced
Have you ever been a patient at our Travel Immunization Centers before? No Yes
If yes, Where? ___ Evanston (closed in 2005) ____ Glenbrook ____ When? _____

Employer: _____
_____

Are you a **NORTHSHORE** employee?_____
If yes, do you have **Aetna Insurance** through NorthShore? _____

1. PLANNED ITINERARY—in EXACT ORDER of travel:
Departure Date_____ Return Date (approximate)_____

Country	(list cities)	Length of Stay	Any Rural Travel (circle)
1.			No Yes
2.			No Yes
3.			No Yes
4.			No Yes
5.			No Yes
6.			No Yes
7.			No Yes
8.			No Yes

Attach printed/detailed itineraries (e.g., from cruise line, travel agent etc.) if applicable.

2. ACCOMMODATIONS: (Check all that apply.)

____Resort ____Cruise Ship ____Private Home ____Camp
____Dormitory ____Small hotels ____Youth Hostel Other_____

3. PURPOSE OF TRAVEL: (Check all that apply.)

____Business ____Teaching ____Biking/Hiking ____Volunteer Organization
____Vacation ____Diving ____Safari ____Foreign Study
____Climbing ____Missionary Other_____

4. MEDICAL HISTORY:

Do you have *ANY* ALLERGIES? (Latex, eggs, fructose intolerance)? (circle) No Yes

If yes, please describe allergy and reaction:_____
_____

Have you ever had any of the following diseases? (Circle yes or no. If yes, give details and dates).

Measles, Mumps, or Rubella(indicate which one)	No	Yes	_____
Chicken Pox or "Shingles"	No	Yes	_____
Heart Disease	No	Yes	_____
Hepatitis/Liver Disease or impaired liver function	No	Yes	_____
Kidney Disease or kidney function problems	No	Yes	_____
Gastrointestinal problems (ulcer, ulceractive colitis, Crohns)	No	Yes	_____
Respiratory Disease (asthma etc.)	No	Yes	_____
Neurological Disorder including MS	No	Yes	_____
Seizure Disorder/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/hyperthyroidism)	No	Yes	_____

5. CURRENT MEDICATIONS: Are you taking *any* medications? (Circle) No Yes

List all current medications and dosage schedules (include oral contraceptives and over-the-counter drugs):

_____ _____
_____ _____
_____ _____

6a. IMMUNE SYSTEM:** Have you ever received any of the following treatments?

Treatment	(Circle)	Reason	Date(s)
Radiation Therapy	No Yes	_____	
Cancer Chemotherapy	No Yes	_____	

Cortisone/Steroids or other medications that affect the immune system? No Yes
Indicate reason and the dosages, form(s) (pills, injection, inhaler, etc.) dates and duration of treatment:

_____
_____

b. Do you live (or work closely with) anyone who has AIDS, an AIDS-like condition, a suppressed immune system, or who is receiving any of the treatments listed above in "6a"? (Circle) No Yes

**(The purpose of these questions is to assist us in assessing any possible risk to you or your contacts from certain immunizations).

7a. PRIOR IMMUNIZATIONS: Indicate month/year of all doses received. Please respond for each and attach copies of all available immunization records.

_____Tetanus	_____ "Gamma" Globulin
_____Diphtheria	
_____Pertussis	_____ Hepatitis A Vaccine
_____Measles	_____ Hepatitis B Vaccine
_____Mumps	_____Typhoid--Injected
_____Rubella	_____Typhoid--Oral
_____Polio series and booster(s)	_____Yellow Fever
_____Influenza (Flu shot)	_____Cholera
_____Pneumococcal (Pneumonia)	_____Rabies
_____Meningococcal (Meningitis)	_____Japanese Encephalitis
_____Varicella (chicken pox)	Other_____

b. Have you ever had an adverse reaction to any immunization?_____
_____
_____

8. WOMEN ONLY:
Are you pregnant now or do you suspect that you might be pregnant? (Circle) No Yes
Are you planning a pregnancy in the next six months? (Circle) No Yes
When was your last menstrual period? Date_____

9. PHYSICIAN INFORMATION: Who is you personal physician?
Name_____
Address_____ City_____
State_____ Zip_____ Phone_____

10: ADDITIONAL INFORMATION:
Please include any additional information that you think might assist us in preparing your travel health recommendations._____
_____
_____
_____

Please check to make sure that you have answered **ALL** of the questions.
Incomplete forms may delay processing.

Please sign below and return the completed form to initiate the preparation of your travel health recommendations and immunizations **(unsigned forms cannot be processed).**

_____ _____
Signature **Date**

Pharmacy Information: NAME_____
Phone number_____
Address _____

Notice and Acknowledgement

I acknowledge that I have received NorthShore's Notice of Health Information Practices.

_____ _____
Witness Date Patient's or Personal Representative Signature

_____
Personal Representative Relationship to Patient

Patient unable to sign. Reason: _____

Notice of Health Information Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information
Each time you visit NorthShore University HealthSystem a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information is often referred to as your health or medical record.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of this notice of health information practices
- Inspect and obtain a copy of your health record
- Request an amendment to your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities
This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new . a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.
For example: We will provide your physician, the hospital or a subsequent healthcare provider with copies of various reports from your medical record that should assist him or her in treating you.
We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
We will use your health information for regular health operations.
For example*:* Members of the professional staff, quality improvement team, may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Disclosures permitted without authorization WITH opportunity to agree or object:

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person of your choice, your location, and general condition.

Facility Directory: Patients will be listed in the hospital directory with disclosure to persons who ask for the individual by name. Only the patient's name, location in the facility and condition in general terms will be disclosed unless the patient opts out of this listing at the time of registration.

Clergy: Patients will be listed on the religious census available to community clergy or designated representatives unless the patient opts out of this listing at the time of registration or upon follow up from the hospital clergy.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment for health care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not rent or sell patient information. If a patient wishes to opt out of receiving further information they may call the Marketing Department at (847) 570-3187 or send a written request to 1603 Orrington, Suite 1120, Evanston IL. 60201.

Fund raising: We may contact you as part of a fund-raising effort. If you prefer not to receive fundraising letters from us, please let us know by contacting the ENH Foundation at 224.364.7200.

Other Disclosures permitted without authorization and WITHOUT opportunity to agree or object:

Business associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do. To protect your health information, however, we require all business associates to appropriately safeguard your information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy or your health information.

Coroner, Funeral Director and Organ procurement organizations: We may disclose personal health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose personal health information to a funeral director as authorized by law in order to permit the funeral director to carry out their duties. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donations and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities relating to the oversight of the healthcare system.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. Report vital events such as birth or death, as well as, other occurrences when required by Illinois Stat Law.

Report of abuse, neglect or Domestic Violence: We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law.

Specified Government Functions: In certain circumstances, the Federal regulations authorize the provider to use or disclose your protected health information to facilitate specified government functions.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena

Effective Date: April 14, 2003

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Acknowledgement of Self Pay Services

We are pleased that you have chosen NorthShore Travel Center to help you prepare for your trip, or to continue your travel immunization series. In order to avoid any confusion regarding our billing protocol, we would like to provide you with the information listed below.

- **NorthShore Travel Center is a *self pay* clinic.**
  - **We do not bill insurance.**
  - **We do not issue claim forms.**
  - **We do not correspond with insurance carriers or third party administrators.**
  - **We do not call for pre-certification.**
  - **We do not call for authorizations.**
- Payment is required at the time of service and can be made by credit card, cash or check.
- NorthShore Travel Center is not a Medicare provider.
- The cost of each vaccine varies and the fee will be provided at the time of your appointment.
- Please keep in mind most insurance companies ***do not*** reimburse for travel immunizations. NorthShore Travel Center does not guarantee that your insurance will cover any of the services provided. If you feel the service is covered by insurance, we suggest that you schedule your travel immunizations through your primary care physician.
- Please do not refer your pharmacy to our office for authorization. We cannot provide any authorization for prescriptions.

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

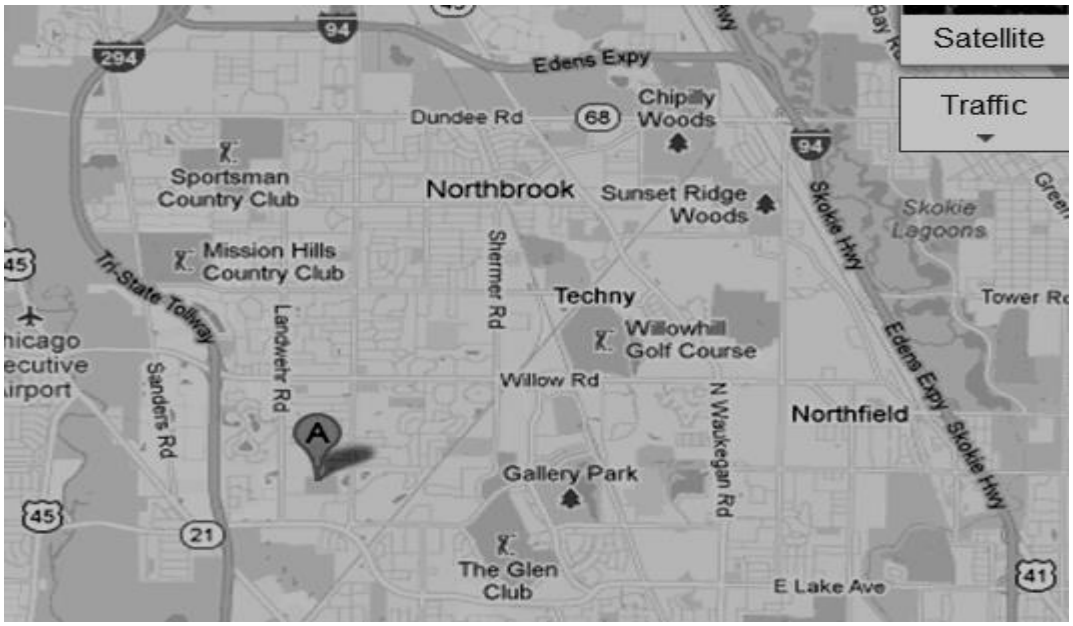
_____

Patient Signature Date

_____

Patient Name (Printed)

MAP TO GLENBROOK HOSPITAL
TRAVEL CENTER



Glenbrook Hospital Campus

Glenbrook Medical Office Building, North

2150 Pfingsten Road, Suite 3000
Glenview, IL 60026
Phone: (847) 657-1700

From the Northwest Suburbs:
Take I-294E (Tri-State Tollway) South and exit at Willow Rd. Turn left and proceed east on Willow Rd. (Follow the blue hospital signs). Turn right on Landwehr Rd. and proceed to the first stop light which is Hospital Drive. Turn left and park in the west parking lot on the left side – Landwehr Entrance. Enter through the Ambulatory Care Center.

From the South:
Take I-94W (Edens Expressway) north and exit at the Lake Ave west-bound exit. Go west on Lake Ave. approximately three and a half miles. Turn right on Pfingsten Rd. and head north to Glenlake Drive which is the second stop light. Turn left and head to the west end of the Glenbrook Hospital Campus – Landwehr Entrance. Enter through the Ambulatory Care Center.

From the West:
Take Euclid Ave. east (Euclid becomes Lake Ave. at I-294), turn left on Landwehr Rd. and head north to the stop light which is Hospital Drive. Turn right and park in the west parking lot on the left side – Landwehr Entrance. Enter through the Ambulatory Care Center.

Park in the West parking lot and enter through the Ambulatory Care Center (Landwehr Entrance). After you enter the building, go to the right and proceed to the end of the walkway. Go left to the Medical Office Building North. Take "Elevator F" to the 3rd floor and check-in at the Travel Center/OMEGA reception desk in Suite 3000.