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 on the Glenbrook Hospital campus in the **Medical Office Building – North, Suite 3000**. Enclosed is the Travel History Form. Please complete this form and return it to us by **email to Travel_Center@northshore.org (preferred)**, by fax (847) 657-1759, or drop it off at our office. If you need to return the forms by mail, please allow 3 weeks from date of mailing for delivery to our office.

A separate Travel Health History form is required for each individual traveler. A Board Certified Infectious Disease physician in partnership with a Registered Nurse specializing in Travel will review all travelers' health histories. We ask that you return your paperwork by the deadline specified when you made your appointment in order to allow enough time for your history to be properly reviewed. Failure to return forms by the deadline may result in having to reschedule your appointment. The Travel Nurse will be providing the consultation and immunizations at your appointment.

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
Travel Health Nurse
Julia Jackson, MA/PSA Travel Concierge

Travel Health and Immunization Services Fee Schedule

Initial Travel Health Consultation ……..……$52.00/75.00**
(pricing varies based on level of services received)

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: _____

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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.

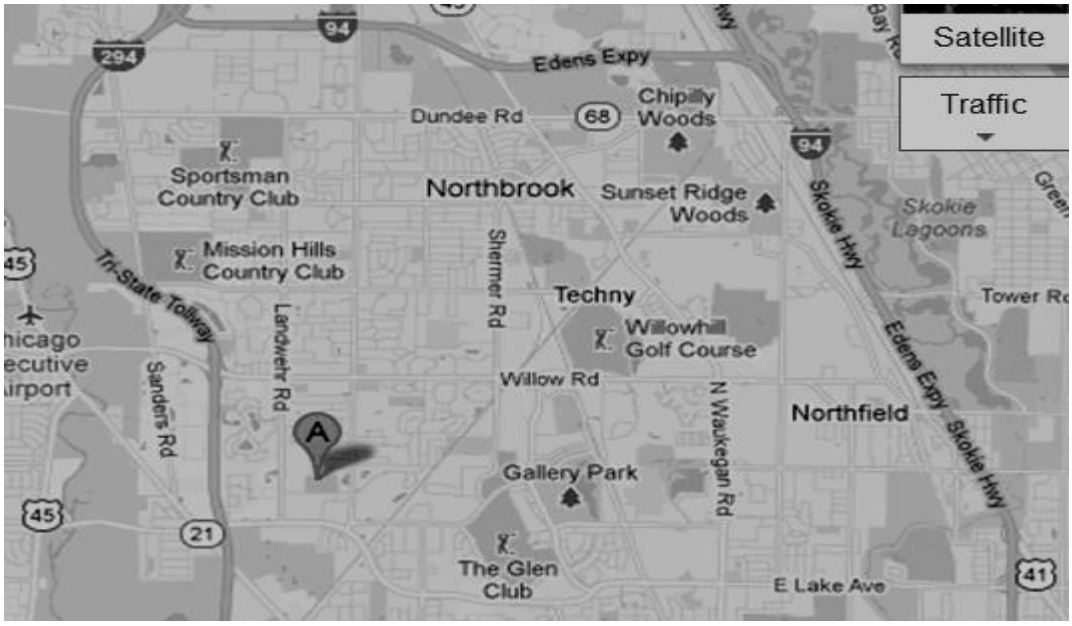
_____

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

Park on the west side of the hospital campus – GREEN – 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 following the signs for the North Medical Office Building passing the Gift Shop and Pharmacy. At the Atrium entrance, go left to Elevator F. Take Elevator F to the 3rd floor and check-in at the Travel Center/OMEGA reception desk in Suite 3000.