Connecticut Travel Medicine

(A Service of Mansfield Family Practice, LLC)
34 Professional Park Road
Storrs, Connecticut 06268
860/487/0002
860/429/1663 (fax)

Today's Date: ______________ **Date and Time of Appt:** __________

Dear Traveler:

We are looking forward to meeting with you to review your travel plans and to help prepare you for your upcoming trip. At your visit, we will review your personal medical history, your itinerary, immunizations and previous travel experience.

Please fill out the enclosed form (one copy for each individual who will be traveling) and bring it with you to the appointment. Please include accurate dates of all previous vaccinations (get your vaccination records from your doctor)

The fees for the appointment will vary with the level of service provided. Depending on your insurance coverage, **you may be asked to pay all fees in full at the time of the visit.** Typical charges may be $250 to $600, or more, depending on the specific immunizations needed. Some travelers may need two or three appointments to complete a schedule of required or recommended immunizations.

Please contact your insurance company or managed care plan to determine the level of insurance coverage for this visit. Specify you are coming for a travel visit. If they ask for a CPT code you may specify 99204. If your insurance company denies coverage you will be responsible for the fees. These are some common vaccinations you may or may not require depending upon your travel destination and immunization history:

Vaccine	CPT Code	Fee
Typhoid	90691	$55.00
Yellow fever	90717	$80.00
Hepatitis A	90632	$82.00
Japanese Encephalitis	90735	$125.00
Tetanus	90718	$50.00
Meningococcal	90733	$135.00
Hepatitis B	90746	$77.00

Thank you for choosing Connecticut Travel Medicine for your pre-travel preparation.

CONNECTICUT TRAVEL MEDICINE

34 Professional Park Road
Storrs, Connecticut 06268
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Fax: 860/426/1663

Please fill out this form and bring it with you to your appointment. One copy should be completed for **each individual** who will receive pre-travel advice.

Name:		
Address:		
City:	State:	Zip:
Telephone(voice):	(fax):	

When are you leaving on your trip? ________________ For how long will you be away? ____________________

What countries will you visit? ____

____

Do you have medication or other ALLERGIES, i.e. penicillin, sulfa, hay fever, asthma? (please list below)

____

Are you currently taking any MEDICATION daily? (include both prescribed and non-prescribed medications of all types):

____

Are you currently being treated for:
Heart disease or high blood pressure? NO/YES (give details)

____

Ulcer/indigestion or intestinal disease? NO/YES (give details)

____

Psychiatric or emotional problems? NO/YES (give details)

____

Immune deficiency of any type? NO/YES (give details)

____

Have you had a splenectomy? NO/YES (give details)

____

Have you had stomach surgery? (gastrectomy or other?) NO/YES (give details)

____

Are you now pregnant or might you be pregnant? NO/YES

List dates for the following immunizations(check with your family doctor or refer to your yellow WHO immunization card):

IMMUNIZATION	DATE GIVEN	IMMUNIZATION	DATE GIVEN
Cholera:		Meningococcal	
dT (diptheria tetanus)		Mumps	
Gamma globulin		Polio (OPV or IPV)	
Hepatits A (Havrix)		Rabies	
Hepatits B		Rubella	
Japanese encephalitis		Typhoid (injection)	
MMR		Typhoid (oral)	
Measles		Yellow fever	