



TravelSafe Clinic

PHARMASAVE®
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and 2957 West Broadway

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CLIENT INTAKE FORM 2 - PLEASE FILL OUT SECTIONS A & C ONLY

SECTION A										
Last Name:			Middle Initial:		Date:					
First Name:			Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Personal Health Number:					
Date of Birth:	Y		M		D		Age:		Email:	CDN Citizen: <input type="checkbox"/> Y <input type="checkbox"/> N
Address:				City/Prov:			Postal Code:			
Name of Guardian:			Child's Weight:		Parental Consent (Signature):					
Your Tel #:		Emergency Contact (EC) Tel #:			Name of EC:					
I agree TravelSafe Clinic can email me a reminder for my booster vaccine(s): <input type="checkbox"/> Y <input type="checkbox"/> N										
PLEASE SELECT THE REASON FOR YOUR APPOINTMENT WITH TRAVELSAFE CLINIC:										
OCCUPATIONAL HEALTH: <input type="checkbox"/> YES <input type="checkbox"/> NO			If YES, what is the name of your school or employer?							
<i>FOR STUDENTS ONLY</i>		I agree to allow TravelSafe Clinic to inform my school of my vaccine records: <input type="checkbox"/> Y <input type="checkbox"/> N								
IMMIGRATION: <input type="checkbox"/>					HAJJ: <input type="checkbox"/>					
ALLERGIES:					MEDICATIONS:					
Current Medical Conditions:										

SECTION B		SECTION C	
Immunization History	Last Dose	Medical History	Yes / No
1. Tetanus / Diphtheria		1. Fever in last 24 hours?	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Measles, Mumps & Rubella		2. Fainted or felt dizzy from an injection?	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Polio		3. Immune suppression (i.e. HIV, cancer)? Taking immune suppression medication?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
4. Varicella (Chicken Pox)		4. G6PD deficiency?	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Pertussis (Whooping Cough)		5. History of anxiety or depression?	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Hepatitis A		6. Digestive disorders (IBS, Colitis, Crohn's)?	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Hepatitis A / Typhoid (Vivaxim)		7. Pregnant or planning pregnancy?	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Hepatitis B		8. Heart disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Hepatitis A / B (Twinrix)		9. Diabetes?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ		10. Disorder of liver, spleen or kidney?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. <input type="checkbox"/> ACYW-135 <input type="checkbox"/> MenC		11. Recent blood transfusion or blood products?	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Yellow fever		12. Thymus disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Japanese encephalitis		13. Seizures, epilepsy?	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Rabies		14. History of Guillain-Barre Syndrome?	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Dukoral		15. Bleeding disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Influenza		16. Other?	<input type="checkbox"/> Y <input type="checkbox"/> N
17. <input type="checkbox"/> Pneumo23 <input type="checkbox"/> Prevnar13		HEALTH HISTORY NOTES (For Medical Staff Only):	
18. HPV (Gardasil 9)			
19. <input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix			
20. Other			

Consultant's Initials:	
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Client's Name:								
Date Stamp 1				Date Stamp 2				
Recommended Vaccine	Dose	Lot #	Price \$	Recommended Vaccine	Dose	Lot #	Price \$	
<input type="checkbox"/> Td <input type="checkbox"/> TdP <input type="checkbox"/> Tdap	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> B		\$	<input type="checkbox"/> Td <input type="checkbox"/> TdP <input type="checkbox"/> Tdap	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> B		\$	
Polio	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> B		\$	Polio	<input type="checkbox"/> B		\$	
MMR	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	MMR	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	
Varicella	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Varicella	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	
Hepatitis A	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Hepatitis A	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	
Hepatitis B	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Hepatitis B	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	
Hepatitis A / B (Twinrix)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Hepatitis A/B (Twinrix)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	
Hepatitis A / Typhoid (Vivaxim)	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Hepatitis A/Typhoid (Vivaxim)	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	
Rabies	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Rabies	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	
Yellow fever	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	Yellow fever	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	
Meningitis (ACYW-135) / B	<input type="checkbox"/> 1		\$	Meningitis (ACYW-135) / B	<input type="checkbox"/>		\$	
Japanese encephalitis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> B		\$	Japanese encephalitis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> B		\$	
Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ	<input type="checkbox"/>		\$	Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ	<input type="checkbox"/>		\$	
Dukoral	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	Dukoral	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	
Influenza	<input type="checkbox"/>		\$	Influenza	<input type="checkbox"/>		\$	
Pneumococcal 23	<input type="checkbox"/> 1		\$	Pneumococcal 23	<input type="checkbox"/> 1		\$	
Pneumococcal / Prevnar 13	<input type="checkbox"/> 1		\$	Pneumococcal / Prevnar 13	<input type="checkbox"/> 1		\$	
<input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	<input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	
HPV (Gardasil 9)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	HPV (Gardasil 9)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	
Other			\$	Other			\$	
Consult Fee			\$				\$	
Immunizer's Initials:		TOTAL \$	\$	Immunizer's Initials:		TOTAL \$	\$	
TB SECTION – TO BE COMPLETED BY MEDICAL STAFF ONLY							Lot #	Price \$
History of BCG <input type="checkbox"/> Yes <input type="checkbox"/> No	History of Positive TST <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, 939 req given/faxed to TB Control <input type="checkbox"/>		Country of Origin:				
Date TST Administered:	Time:	RN Signature:					\$	
Date TST Read:	Time:	RN Signature:						
➔ Result (48-72 hrs later) <input type="checkbox"/> Neg <input type="checkbox"/> Pos						If Positive: <input type="checkbox"/> Swelling <input type="checkbox"/> Redness / Induration <input type="checkbox"/> Other reaction (describe):		
➔ Follow-up: <input type="checkbox"/> No further follow-up <input type="checkbox"/> Repeat in 2 Weeks <input type="checkbox"/> Recommended chest x-ray <input type="checkbox"/> 939 requisition given						Measurement mm:		
2 Step Date TST Administered:	Time:	RN Signature:					\$	
Date TST Read:	Time:	RN Signature:						
➔ Result (48-72 hrs later) <input type="checkbox"/> Neg <input type="checkbox"/> Pos						If Positive: <input type="checkbox"/> Swelling <input type="checkbox"/> Redness / Induration <input type="checkbox"/> Other reaction (describe):		
➔ Follow-up: <input type="checkbox"/> No further follow-up <input type="checkbox"/> Recommended chest x-ray <input type="checkbox"/> 939 requisition given						Measurement in mm:		
CLINIC NOTES:							TOTAL \$	\$
Lab Work:	<input type="checkbox"/> HepBsAb <input type="checkbox"/> HepBsAg <input type="checkbox"/> Varicella <input type="checkbox"/> MMR <input type="checkbox"/> Rabies <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Requisition Given							
Routine Schedule:	<input type="checkbox"/> 0, 1, 6 months Hepatitis B Twinrix <input type="checkbox"/> 0, 6 months Hepatitis A <input type="checkbox"/> 0, 0, 6 months Hepatitis B Twinrix							
	<input type="checkbox"/> 0, 2, 6 months Gardasil 9 <input type="checkbox"/> 0, 2-6 months Shingrix <input type="checkbox"/> 0, 7, 21-28 days Rabies <input type="checkbox"/> 0, 7 days Japanese Enc <input type="checkbox"/> 0, 28 days Japanese Enc <input type="checkbox"/> 12-24 months							
Rapid Schedule:	<input type="checkbox"/> 0, 7, 21 days, 1 year Hepatitis B Twinrix <input type="checkbox"/> 0, 4+ weeks MMR <input type="checkbox"/> 0, 6 weeks Varicella							
Date Stamp 3								
Vaccine	Dose	Lot #	Price \$	Vaccine	Dose	Lot #	Price \$	
<input type="checkbox"/> Td <input type="checkbox"/> TdP <input type="checkbox"/> Tdap	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> B		\$	Meningitis	<input type="checkbox"/>		\$	
Polio	<input type="checkbox"/> B		\$	Japanese encephalitis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> B		\$	
MMR	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ	<input type="checkbox"/>		\$	
Varicella	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Dukoral	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	
Hepatitis A	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Influenza	<input type="checkbox"/>		\$	
Hepatitis B	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Pneumococcal 23	<input type="checkbox"/> 1		\$	
Hepatitis A/B (Twinrix)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Pneumococcal / Prevnar 13	<input type="checkbox"/> 1		\$	
Hepatitis A/Typhoid (Vivaxim)	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	<input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	
Rabies	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	HPV (Gardasil 9)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	
Yellow fever	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	Other			\$	
Immunizer's Initials:		TOTAL \$	\$	Immunizer's Initials:		TOTAL \$	\$	
Date Stamp 4								
Vaccine	Dose	Lot #	Price \$	Vaccine	Dose	Lot #	Price \$	
<input type="checkbox"/> Twinrix <input type="checkbox"/> Hepatitis B	<input type="checkbox"/> 3 <input type="checkbox"/> 4		\$	Rabies	<input type="checkbox"/> 3		\$	
JE/Ixiaro	<input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Other			\$	
Immunizer's Initials:		TOTAL \$	\$	Immunizer's Initials:		TOTAL \$	\$	
CLINIC NOTES:								