

Dear Traveler:

Thank you for contacting the Endeavor Health 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 Endeavor Health 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 Endeavor Health Travel Center.

Sincerely,

Kathleen Freemon, RN, COHN
Travel Health Nurse
Jessica Draut, 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.

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

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.

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 an **Endeavor Health** employee? _____
 If yes, do you have **Cigna Endeavor Employee Plan**? _____

Are you a participant in **Site 447**? Yes No

1. PLANNED ITINERARY—in EXACT ORDER of travel:

Departure Date _____ Return Date (approximate) _____

<u>Country</u>	<u>(list cities)</u>	<u>Length of Stay</u>	<u>Any Rural Travel</u>
			(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, ulcerative 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?

<u>Treatment</u>	(Circle)	<u>Reason</u>	<u>Date(s)</u>
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	_____ Hepatitis A Vaccine
_____ Pertussis	_____ Hepatitis B Vaccine
_____ Measles	_____ Typhoid--Injected
_____ Mumps	_____ Typhoid--Oral
_____ Rubella	_____ Yellow Fever
_____ Polio series and booster(s)	_____ Cholera
_____ Influenza (Flu shot)	_____ Rabies
_____ Pneumococcal (Pneumonia)	_____ Japanese Encephalitis
_____ Meningococcal (Meningitis)	_____
_____ 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 your 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 _____

Acknowledgement of Self Pay Services

We are pleased that you have chosen Endeavor Health 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.

- Endeavor Health 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.
- Endeavor Health 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. Endeavor Health 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.

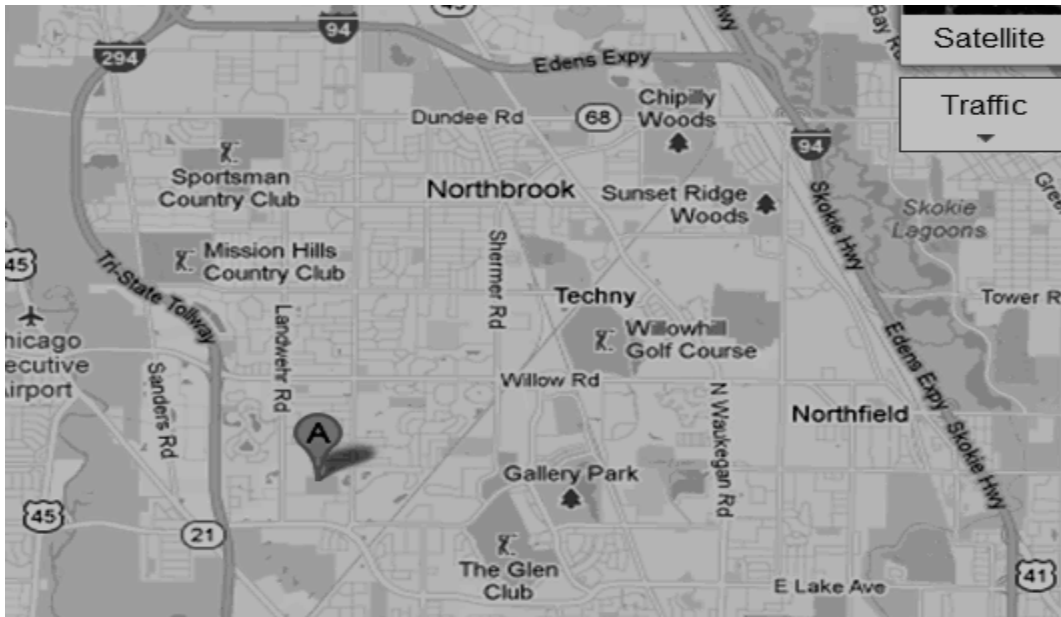
I have read the above, and acknowledge that I understand the statements listed.

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.