Sandy Springs Pediatrics
and Adolescent Medicine, PC

Travel Clinic Request Form

Please complete and return this form to travel coordinator. Once we receive and review this form we will contact you to schedule your travel consult visit.

General:

Patient Name: ____________________ Date of Birth: _______________________

Phone: _________________________________

Are you an established patient at Sandys Springs Pediatrics? YES NO

If NO, please complete *New Patient Paperwork Form* in addition to this form

Itinerary:

List all stops in chronological order for your planned travel. This **includes** any layovers even if you do not disembark.

City and Country #1:	Mode of Travel:	Arrival Date:	Departure Date:	Duration:
City and Country #2:	Mode of Travel:	Arrival Date:	Departure Date:	Duration:
City and Country #3:	Mode of Travel:	Arrival Date:	Departure Date:	Duration:
City and Country #4:	Mode of Travel:	Arrival Date:	Departure Date:	Duration:
City and Country #5:	Mode of Travel:	Arrival Date:	Departure Date:	Duration:
City and Country #6:	Mode of Travel:	Arrival Date:	Departure Date:	Duration:

Total Duration: ________________

1. What is the purpose of the patient's travel? (i.e. vacation, business, relocation, mission, study, etc.)

2. Describe any planned activities (i.e. hiking, caving, water activities, working with animals, etc.)

3. To what type of area will the patient travel to? Urban/rural/urban and rural

4. What type of accommodations will the patient be staying in? (i.e. hotel, resort, family home, hostel, etc.)

Medical History:

1. Has the patient ever received the Yellow Fever vaccine ? YES NO

2. Has the patient ever had an adverse reaction to any injections? YES NO
   If YES, please describe:

3. Check box if the patient has allergies to any of the following.

☐ Sulfa	☐ Eggs	☐ Egg products
☐ Chicken protein	☐ Gelatin	
☐ None		

4. Does the patient you have a history of any anaphylactic reaction including medications, foods, or insect bites? YES NO
   If YES, describe:

5. Has the patient ever taken malaria prophylaxis? YES NO
   If YES, what medication:

6. Check box if the patient has a history of any of the following.

☐ Nightmares	☐ Seizure/Epilepsy	☐ Insomnia
☐ Depression	☐ Mental Health Disorder	☐ Cancer
☐ Immune Deficiency	☐ G6PD Deficiency	☐ Thymus Disorder
☐ HIV/AIDS	☐ Organ Transplant	☐ Radiation Therapy
☐ None of these		

7. List ALL current medications, including prescription, non-prescription, supplements, oral contraceptive pills:

8. Has the patient had any blood product transfusions or injections in the last 12 months (i.e. blood transfusion, IVIG, VZIG, etc.)? YES NO

9. Is the patient currently or is there a chance that the patient could become pregnant during travel? YES NO

Please note that Travel Consults are not covered by insurance carrier. You will be require to self-pay for the visit and any vaccines if needed.

Office Use Only

Schedule with Dr. Robertson______________ Schedule with Any Provider_______________________

Notes: ____

Signature: ____ Date: ___________________________

Scheduled: (circle one) Yes or No Date: ________________________

Updated 11/30/23