

# 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	\$120.00
Yellow fever	90717	\$115.00
Hepatitis A	90632	\$82.00
Japanese Encephalitis	90738	\$260.00
Tetanus	90715	\$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  
Telephone: 860/487/0002  
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):

<u>IMMUNIZATION</u>	<u>DATE GIVEN</u>	<u>IMMUNIZATION</u>	<u>DATE GIVEN</u>
Cholera:	_____	Meningococcal	_____
dT (diphtheria tetanus)	_____	Mumps	_____
Gamma globulin	_____	Polio (OPV or IPV)	_____
Hepatitis A (Havrix)	_____	Rabies	_____
Hepatitis B	_____	Rubella	_____
Japanese encephalitis	_____	Typhoid (injection)	_____
MMR	_____	Typhoid (oral)	_____
Measles	_____	Yellow fever	_____