OHS Pre-Appointment Form for Traveling Residents

PERSONAL INFORMATION

Traveler's Name: _____ Date: _____

Department Name: _____ Email Address: _____

Work Telephone Number/Pager: _____ Cell Number: _____

TRIP INFORMATION

Have you traveled internationally in the past? ☐ Yes ☐ No

Itinerary (locations and dates): Please provide full itinerary of travel. Please list all countries (and areas within) that will be visited, as well as any layovers in your travel. PLEASE INCLUDE DATES.

1.

2.

3.

4.

5.

Names of Clinics/Hospital to be visited:

1.

2.

3.

Destination: ☐ Urban ☐ Rural ☐ Remote ☐ High altitude ☐ Beach

Purpose of business trip: ☐ Medical Care ☐ Education
☐ Research ☐ Other (i.e. shadowing):

Will you be performing or taking part in invasive procedures (e.g., surgery, blood drawing): ☐ Yes ☐ No
Will you have potential exposure to blood or body fluids: ☐ Yes ☐ No
Will you be working with mammalian animals: ☐ Yes ☐ No

HEALTH HISTORY

Do you have any chronic health problems for which you take medication on a regular basis and see a health care provider? ☐ Yes ☐ No
If yes, please explain:

Are you currently being treated for any health problem? ☐ Yes ☐ No
If yes, please explain:

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ALLERGIES

Medication(s)	☐ Yes	☐ No	If yes, describe: _____
Reaction to vaccine	☐ Yes	☐ No	
Egg or other food	☐ Yes	☐ No	
Bee sting	☐ Yes	☐ No	
Animals	☐ Yes	☐ No	
Environmental	☐ Yes	☐ No	

(Pollens, dust, hay fever, etc.)

Have you ever experienced anaphylaxis (severe allergic reaction): ☐ Yes ☐ No

Do you have a prescription for an epi-pen: ☐ Yes ☐ No

MEDICATIONS

Please list ALL prescribed and over-the-counter medications and supplements that you use:

Medication or supplement	Reason for use
1.	
2.	
3.	

IMMUNIZATIONS (dates of all prior immunizations) *WE DO NOT HAVE ALL OF THIS INFORMATION AT OCCUPATIONAL HEALTH. PLEASE CHECK YOUR MEDICAL RECORDS.*

Hepatitis B: _____ anti-HBsAg titer: _____

Hepatitis A: _____

MMR: _____

Varicella: _____

Tdap: _____ Td:_____

Typhoid (specify oral vs IM):_____

Rabies: _____

Meningococcal – MenACWY: _____

Meningococcal – MenB: _____

Yellow fever: _____

Japanese encephalitis: _____

FEMALES

Are you currently pregnant?	☐ Yes	☐ No
Are you trying to become pregnant?	☐ Yes	☐ No

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HIV POST-EXPOSURE PROPHYLAXIS

Will you be providing clinical care? (If No, please skip to next section) ☐ Yes ☐ No

Does your clinical site provide HIV Post-Exposure Prophylaxis? ☐ Yes ☐ No

It is the responsibility of the resident to verify that the international site(s) where they will be visiting are equipped with appropriate HIV post-exposure prophylaxis. Please contact your clinical site (or the organization with which you are traveling) and inquire about the needlestick/blood exposure protocols. Specifically, we need documentation of what medications they have available for HIV post-exposure prophylaxis and that the medications are immediately available to you after an exposure (at no cost.)

Submit this completed form via email to Nina.Ivie@unchealth.unc.edu

or **Courtney.Fletcher@unchealth.unc.edu** 6-8 weeks prior to travel. You will receive a confirmation email that this form has been received. Once the completed form has been reviewed by Occupational Health, you will be contacted with an appointment date and time.

Please note: Appointments will not be scheduled same day and generally will not be scheduled that same week due to previous standing appointments. Failure to secure an appointment at Occupational Health within a minimum of 4 weeks from your departure date may result in official residency travel being prohibited.

_____ _____

Traveler's Signature Date

_____ _____

OHS Medical Provider's Signature and Title Date