

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 6-8 weeks prior to travel to the following:

- Nina Ivie - Nina.Ivie@unchealth.unc.edu
- Tracy Watson - Tracy.Watson@unchealth.unc.edu
- Barbara Kaczmariski - Barbara.Kaczmariski@unchealth.unc.edu

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