INTERNATIONAL Medicine Center
Experts in Tropical + Travel Medicine

Please fax back back to: 713-973-0805

DESTINATION (*Required*): _____ Length of **Stay:**_____ **Departure Date**: _____
_____

Name:_____**AGE:**_____MED**KIT:** _____Basic____Full
Height:_____Weight:_____**DOB:**_____
Address:_____
_____
Phone:_____
E-mail:_____
Company:_____
Cost Center/PO/SAP#_____
(**Global Santa Fe** Employees must indicate Cost Center & SAP #)

MEDICATIONS/KIT/SUPPLY REQUESTED:

MEDS:
- ☐ Cipro
- ☐ Tamiflu
- ☐ Doxycycline
- *☐ **Tramadol 50mg**
- ☐ Malarone
- ☐ Relenza
- ☐ Lariam
- ☐ **Tamazepam**
- ☐ ___DEET ___Permethrin
- *☐ **Zolpidem**: Ambien CR:___6.25mg 12.5mg
  Ambien: ___5mg ____10mg
  #____10____20: Other:_____
- *☐ **OTHER**:_____
  _____

PATIENT INFORMATION UPDATE:
NEW MEDICAL PROBLEMS**:**

CURRENT MEDICATIONS:

ALLERGIES: _____N _____Y
CHRONIC DISORDERS:

*__CONTROLLED SUBSTANCES REPORT__

Pharmacy: _____
Staff Name

MED:	Last Refill	Refills/Yr	Last OV
_____	_____	_____	_____
MED:			
_____	_____	_____	_____
MED:			

PHYSICIAN VISIT SECTION Date_____
Discussed with patient,
___Sleep med ___Pain med (proper use)
___Other: _____
_____
_____
_____

MEDICATION DELIVERY/PICK-UP **Refill Charge**
Today's Date: _____ Time: _____
___ Client Using ABx Pharmacy ___$45.00
___ Own Pharmacy: _____ ___$60.00
(name/phone)
___ Client **picking up** meds **here**: Date: _____Time:_____
___ Deliver ****** meds to:
_____ Date: _____Time:_____
****Delivery Charge depends on destination**
___Bill Client (traveler)
___Bill Company: _____

For Internal Use Only:
Non-MD Staff: MAKE SURE ABOVE **TRIP DEPARTURE DATE** IS COMPLETED **BEFORE GIVING TO M.D**
How soon does patient need refill?_____ **URGENT?**_____
Last OV:_____ Last Filled_____No. Times Refilled Past Yr._____Avg. Amt./Refill_____
Outstanding Balance $: Patient_____ Company_____
☐ **Business Staff:** Given above BALANCE, OK to refill med ___Y___N, **OR** have patient settle balance _____Y ___N
If patient using ABx Pharmacy, should we give med prior to settling Outstanding Balance? _____Y ___N
Comments:

MD Section:☐ See above Business Staff Section **Refill? Y**_____ **N**_____ Amt: #_____ _____d _____wk _____mo
MUST MAKE APPT:_____ Pre-Rx:_____ Pre-Further Refills:_____ **M.D. Initials**:_____ **Date:**_____

If **REFILL** answer is **NO** (Business or Pharm/Nursing Staff), **write comments or discuss** with physician.
Rx Denied___Y ___N Reason:_____
Nursing: Reviewed By:_____ If **Rx** denied, CONTACTED:_____ PATIENT _____COMPANY _____
Was a copy of request given to Pharmacist?_____Y _____N, **Rx called in to:**_____
Chart Reviewed By:_____ Fee for chart review submitted:_____Y ____N
Request filed in Chart: _____Y ____N **FILLED** By:_____

+

COMMENTS:
___Provide **Return Office Visit Form** to Physician
___ Record in **IMC TRACKING LEDGER**
under Refills _____ **Initials** (done)