PHARMACIE
Carole Cyr

Traveler's Health Consultation Demand

PATIENT IDENTIFICATION

Name: _____ First name: _____

☐ Male ☐ Female Weight: _____ Date of birth: _____/_____/_____

Allergies: _____ Intolerances : _____ Smoking: _____/day Alcohol:_____/wk

☐ Pregnancy/N° weeks: _____ ☐ Breastfeeding: _____

☐ RAMQ : _____ ☐ Private insurance : _____

TRAVELING INFORMATION

Destination: (Cities / Regions) _____

Departure date :_____ Length of stay : _____

☐ Leisure / Resort hotel ☐ Business ☐ Student exchange
☐ Friends/family ☐ Organized group travel ☐ Extreme sports: _____
☐ Wild expedition ☐ Prolonged stay ☐ Rainy season

☐ Please bring your IMMUNIZATION RECORD to your appointment

Fees for the consultation for each condition : 16$ (a certain amount may be covered by the RAMQ or a private insurance plan)

☐ Traveler's diarrhea
☐ Malaria
☐ Acute mountain sickness

Return this form before your appointment
by **e-mail** at info@pharmaciecarolecyr.com OR by **FAX** at 514-303-1876.

To be filled by the pharmacist : Consultation for ☐ Traveler's diarrhea ☐ AMS ☐ Malaria