PHARMACIST POST-TRAVEL CLIENT ASSESSMENT

<table>
<tr><th colspan="5">Client Information</th></tr>
<tr><td colspan="3">Name:</td><td colspan="2">Provincial Health Services Number:</td></tr>
<tr><td colspan="2" rowspan="2">Address:</td><td colspan="2">Date of Birth:</td><td>Weight: Height:</td></tr>
<tr><td colspan="3">Gender: □ Male □ Female □ Other</td></tr>
<tr><td colspan="2">Tel: Cell:</td><td colspan="3">Email:</td></tr>
<tr><td colspan="2">Parent/Guardian:</td><td colspan="3">Primary Healthcare Practitioner Name:</td></tr>
<tr><td>Emergency
Contact Name:</td><td>Tel:</td><td colspan="3">Tel: Fax:</td></tr>
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☐ **Signs/symptoms of illness while travelling:**

- ☐ **Yes, Describe:**

☐ **Reviewed itinerary, activities to determine if any ongoing health risks**

- ☐ **Yes, Describe:**

☐ **Current signs/symptoms of illness** (if present, describe):

- ☐ **Diarrhea**
- ☐ **Fever**
- ☐ **Skin conditions**
- ☐ **Respiratory conditions**
- ☐ **Chronic health condition status**
- ☐ **Other:**

☐ **Reviewed relevant laboratory work** (if applicable)

☐ **Reviewed tolerability of travel medications**

☐ **Discussed need for additional immunization (e.g. to complete vaccine series) or post-exposure prophylaxis**

☐ **Referred to primary healthcare practitioner** (describe rationale):

☐ **Additional Comments:**

Date Assessment Completed: **Pharmacist's Name:**