INTERNATIONAL Medicine Center
Experts in Tropical + Travel Medicine

Please fax back back to: 713-973-0805

DESTINATION (***Required***): ____________________ Length of **Stay:**_______ **Departure Date**: _______
____________________ **MEDICATIONS/KIT/SUPPLY REQUESTED:**

Name:____________________________**AGE:**_______ MED **KIT:** _____Basic_____Full
Height:__________Weight:__________**DOB:**__________ **MEDS:**
Address:______________________________________
____
Phone:______________________________________
E-mail:______________________________________
Company:______________________________________
Cost Center/PO/SAP#_____________________________
(**Global Santa Fe** Employees must indicate Cost Center & SAP #)

MEDS:
- ☐ Cipro
- ☐ Tamiflu
- *☐ **Tramadol 50mg**
- ☐ Malarone
- ☐ **Temazepam**
- ☐ ___DEET ___Permethrin
- *☐ **Zolpidem**: 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

	Last Refill	Refills/Yr	Last OV
MED: ___________	______	______	______
MED: ___________	______	______	______
MED:			

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: ____________________________

PHYSICIAN VISIT SECTION Date__________
Discussed with patient,
___Sleep med ___Pain med (proper use)
___Other: ______________________________
____
____

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)