PREVENTIVE CARE

TRAVEL MEDICATIONS

STATEWIDE DRUG THERAPY MANAGEMENT PROTOCOL for the OREGON PHARMACIST

AUTHORITY and PURPOSE:

- Per ORS 689.645, a pharmacist may provide patient care services pursuant to a statewide drug therapy management protocol.
- Following all elements outlined in OAR 855-115-0330 and OAR 855-115-0335, a pharmacist licensed and located in Oregon may prescribe pre-travel medications.
  - Malaria prophylaxis
  - Traveler's diarrhea
  - Altitude illness prophylaxis
  - Motion sickness

STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:

- Utilize the standardized Travel Medications Patient Intake Form (pg. 2-3)
- Utilize the standardized Travel Medications Assessment and Treatment Care Pathway (pg. 4-10)
- Utilize the standardized Travel Medication Prescription Template *optional* (pg. 11)
- Utilize the standardized Travel Medication Provider Notification (pg. 12-13)
- Utilize the standardized Travel Medication Patient Visit Summary (pg. 14)

PHARMACIST TRAINING/EDUCATION:

- APhA Pharmacy-Based Immunization Delivery certificate (or equivalent); and
- Minimum of 4 hour comprehensive training program related to pharmacy-based travel medicine services intended for the pharmacist (one-time requirement); and
- A minimum of 1 hour of travel medication continuing education (CE), every 24 months.

RESOURCES:

- CDC Yellow Book 2024: Health Information for International Travel. Oxford University Press; 2023. https://wwwnc.cdc.gov/travel/page/yellowbook-home.

PROPOSED

Travel Medication Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

PATIENT INFORMATION

Date _____/_____/________ Date of Birth _____/_____/________ Age_______

Legal Name____ Name ___________________________

Sex Assigned at Birth (circle) M / F Gender Identification (circle) M / F / Other______

Pronouns (circle) She/Her/Hers, He/Him/His, They/Them/Their, Ze/Hir/Hirs, Other_________________________________

Street Address ____

Phone ( ) __________________________________ Email Address ______________________________________

Healthcare Provider Name _______________________ Phone ( ) ________________ Fax ( ) _______________

Do you have health insurance? Yes / No Insurance Provider Name ________________________________

TRAVEL SPECIFICS

Purpose of Trip: ____

Activities: ____

Departure Date: _________________ Return Date: _________________

List Countries **AND** Cities to be Visited Chronologically (Include Layovers)	Arrival Date	Departure Date

Have you traveled outside the United States before? □ Yes □ No

If yes, where and when?

____

____

1.	Will you ONLY be using airplane as your mode of transportation If no, explain: ____	□ Yes □ No □ Not sure
2.	Will you ONLY be visiting major cities? If no, explain: ____	□ Yes □ No □ Not sure
3.	Will you ONLY be staying in hotels? If no, explain: ____	□ Yes □ No □ Not sure
4.	Will you be visiting friends and family?	□ Yes □ No □ Not sure
5.	Will you be ascending to high altitudes? (≥8,000 ft or 2,450 meters) in the mountains	□ Yes □ No □ Not sure
6.	Will you be working in the medical or dental field with exposure to blood or bodily fluids?	□ Yes □ No □ Not sure

PROPOSED

Travel Medication Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

ALLERGIES

□ No known drug or vaccine allergies □ No known food allergies

Drug/Vaccine Allergies: (describe reaction-e.g., rash, hives, anaphylaxis, etc.)

____

Food Allergies: (describe reaction- e.g., rash, hives, anaphylaxis, etc.) -

____

VACCINE MEDICAL INFORMATION

Please complete the table below ***(please bring your vaccination record to the pre-travel consult)***

Vaccinations	Yes – *(Enter vaccination date below)*	No	Not Sure
Chikungunya			
Cholera			
COVID-19	Dose 1: 2: Booster(s):		
Haemophilus Influenzae B (HIB)			
Hepatitis A	Dose 1: 2:		
Hepatitis B (Manufacturer):_______________	Dose 1: 2: 3:		
Hepatitis A/B Combo	Dose 1: 2: 3:		
Human Papillomavirus (HPV)			
Influenza			
Japanese Encephalitis	Dose 1: 2:		
Meningococcal B	Dose 1: 2:		
Meningococcal ACWY	Dose 1: 2:		
Measles, Mumps, Rubella (MMR)	Dose 1: 2:		
Pneumonia			
PPSV23			
PCV (Select: 13/15/20)			
Polio			
Rabies	Dose 1: 2:		
Respiratory Syncytial Virus (RSV)			
Shingles	Dose 1: 2:		
Tetanus (Select: Tdap/Td/DTaP/DT)			
Tick-Borne Encephalitis	Dose 1: 2: 3: 4:		
Typhoid (Select: Oral / Injection)			
Varicella	Dose 1: 2:		
Yellow Fever			
Other:			
Other:			

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MEDICAL HISTORY

List your current prescription medications and medical conditions treated (include birth control pills and anti-depressants):

Current Medical Conditions:____

____

Current Prescription Medications:____

____

Regularly used Non-Prescription Medications (over the counter, herbal, homeopathic, vitamins, and supplements including those purchased at health-food stores):____

1.	Are you currently using steroids?	□ Yes □ No □ Not sure
2.	Are you currently receiving radiation therapy?	□ Yes □ No □ Not sure

3.	Are you currently receiving immunosuppressive therapy?	□ Yes □ No □ Not sure
4.	Are you pregnant or are you planning to become pregnant within the next year?	□ Yes □ No □ Not sure
5.	Are you currently breastfeeding?	□ Yes □ No □ Not sure

QUESTIONS/CONCERNS

Please list additional questions or concerns that you might have regarding your travel: ______________________________

____

Signature:____Date:________________

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Travel Medications - Assessment and Treatment Care Pathway

STEP 1: Assess routine and travel vaccinations.
STEP 2: Choose and issue prescription(s) for appropriate prophylaxis medication(s), in adherence to the CDC's 2024 Yellow Book: Health Information for International; https://wwwnc.cdc.gov/travel/page/yellowbook-home and this protocol. Must also include documented screening for contraindications (see pgs. 6-7).
STEP 3: Prescribe medications and administer vaccinations.
STEP 4: Provide a written individualized care plan to each patient.

1. **Malaria Prophylaxis**
   a. **Patient assessment**
      i. Review detailed itinerary
      ii. Identify zones of resistance
      iii. Review recommendations by the CDC
      iv. Discuss planned activities
      v. Assess risk of acquiring malaria and body weight (kg)
   b. **Prophylaxis**
      i. Discuss insect precautions and review signs/symptoms of malaria with patient
      ii. Screen for contraindications
      iii. Assess travel areas for resistance:
         1. **Non-chloroquine resistant zone**
            a. *Chloroquine (Aralen®)*
               Adult dosing: Chloroquine 500 mg
               - Begin 1-2 weeks prior to entering the malaria risk area-1 tablet weekly
               - Take once weekly while in the malaria risk area and for 4 weeks after leaving risk area

               Pediatric dosing:
               8.3 mg/kg (maximum is 500 mg)
               - Begin 1-2 weeks prior to entering the malaria risk area -1 dose weekly
               - Taken once weekly during trip and for 4 weeks after leaving the malaria risk area

            OR

            b. *Hydroxychloroquine (Plaquenil®)*
               Adult Dosing: Hydroxychloroquine 400 mg
               - Begin 1-2 weeks prior to entering the malaria risk area -1 tablet weekly
               - Take once weekly during trip and for 4 weeks after leaving the malaria risk area

               Pediatric Dosing:
               6.5 mg/kg (maximum is 400mg)
               - Begin 1-2 weeks prior to entering the malaria risk area -1 dose weekly
               - Take once weekly during trip and for 4 weeks after leaving the malaria risk area
         2. **Chloroquine-resistant zone**
            a. Atovaquone/Proguanil (Malarone®)
               Adult Dosing: Atovaquone/Proguanil 250mg/100mg
               - Begin 1 tablet daily 1-2 days prior to entering the malaria risk area
               - Take daily during trip and 7 days after leaving the malaria risk area

               Pediatric Dosing: Atovaquone/Proguanil 62.5mg/25mg
               5–8 kg: 1/2 pediatric tablet daily
               9–10 kg: 3/4 pediatric tablet daily
               11–20 kg: 1 pediatric tablet daily

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21–30 kg: 2 pediatric tablets daily
31–40 kg: 3 pediatric tablets daily
> 40 kg: 1 adult tablet daily

- Begin 1 dose daily 1-2 days prior to entering the malaria risk area
- Take daily during trip and 7 days after leaving the malaria risk area

OR

b. *Doxycycline monohydrate (Monodox®) or hyclate (Vibramycin®) (≥8 years)*
Adult Dosing: Doxycycline 100mg

- Begin 1 tablet or capsule daily 1-2 days prior to entering the malaria risk area
- Take daily during trip and for 4 weeks after leaving the malaria risk area

Pediatric Dosing:
≥8 years old: 2.2 mg/kg (maximum is 100 mg) daily

- Begin 1 dose daily 1-2 days prior to entering the malaria risk area
- Take daily during trip and for 4 weeks after leaving malaria risk area

OR

c. *Mefloquine (Lariam®)*
Adult Dosing: Mefloquine 250mg

- Begin ≥2 weeks prior to entering the malaria risk area -1 tablet weekly
- Take once weekly during travel in the malaria risk area and for 4 weeks after leaving the malaria risk area

Pediatric Dosing:
≤9 kg: 5 mg/kg
10-19 kg: ¼ tablet weekly
20-30 kg: ½ tablet weekly
31-45 kg: ¾ tablet weekly
> 45 kg: 1 tablet weekly

- Begin 1-2 weeks prior to entering the malaria risk area -1 dose weekly
- Take once weekly during and for 4 weeks after leaving the malaria risk area

3. Mefloquine-Resistant zone

a. *Doxycycline monohydrate (Monodox®) or hyclate (Vibramycin®) (≥8 years)*
Adult dosing: Doxycycline 100 mg

- Begin 1 tablet or capsule daily 1-2 days prior to entering the malaria risk area
- Take daily during trip and 4 weeks after leaving the malaria risk area

Pediatric dosing:
≥8 years old: 2.2 mg/kg (maximum is 100 mg) daily

- Begin 1 dose daily 1-2 days prior to entering the malaria risk area
- Take daily during trip and 4 weeks after leaving the malaria risk area

OR

b. Atovaquone/Proguanil (Malarone®)
Adult dosing: Atovaquone/Proguanil 250mg/100mg
Pediatric Dosing: Atovaquone/Proguanil 62.5mg/25mg
5–8 kg: 1/2 pediatric tablet daily
9–10 kg: 3/4 pediatric tablet daily
11–20 kg: 1 pediatric tablet daily
21–30 kg: 2 pediatric tablets daily
31–40 kg: 3 pediatric tablets daily
> 40 kg: 1 adult tablet daily

- Begin 1 dose daily 1-2 days prior to entering the malaria risk area
- Take daily during trip and 7 days after leaving the malaria risk area

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2. Traveler's diarrhea (TD)

a. Patient assessment
   i. Review detailed itinerary and identify travel areas of increased risk
   ii. Assess patient's risk of acquiring traveler's diarrhea and body weight (kg)
   iii. Screen for contraindications
   iv. Consult CDC Yellow Book for list of high-risk factors for TD

b. Prophylaxis education
   i. Discuss dietary counseling, avoidance of high-risk foods, food and beverage selection and sanitary practices, oral rehydration
   ii. Educate patient on how to recognize symptoms and severity of traveler's diarrhea
      1. **Mild:** diarrhea that is tolerable, not distressing, and does not interfere with planned activities
      2. **Moderate:** diarrhea that is distressing or interferes with planned activities
      3. **Severe:** dysentery (bloody stools) and diarrhea that is incapacitating or completely prevents planned activities
   iii. Pharmacotherapy prophylaxis
      Pepto-Bismol®: Two 262-mg tablets or 2 fluid oz (60 mL) QID for up to 3 weeks
      Note: Avoid in patients <12 years old, patients taking doxycycline for malaria prophylaxis, anticoagulants, allergic to aspirin, probenecid, methotrexate

c. Treatment *(Note: while the CDC Yellow Book includes ciprofloxacin, this protocol only permits azithromycin)*
   i. First line for mild TD and adjunctive treatment for moderate TD
      1. *Loperamide (OTC- Imodium® AD)*
         Adult Dosing: Loperamide 2 mg
         - Take 4 mg at onset of diarrhea, followed by additional 2 mg after each loose stool (Max of 16 mg per day)

         Pediatric Dosing:
         - 22 to 26 kg: Take 2 mg after first loose stool, followed by 1 mg after each subsequent stool (Max of 4 mg per day)
         - 27 to 43 kg: Take 2 mg after first loose stool, followed by 1 mg after each subsequent stool (Max of 6 mg per day)
   ii. Antibiotic treatment (for moderate or severe TD)
      1. Consult the CDC Yellow Book for resistance rates to antibiotics
      2. Empiric treatment for moderate TD and severe TD (age <18 requires a prescription from PCP) a
         a. *Azithromycin 500mg*
            • 1 tablet daily for 3 days
            • 1 course/14 days, Max 2 courses for trips >14 days

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3. Altitude Illness

a. Patient assessment/Education
   i. Review detailed itinerary and identify travel areas of increased risk
   ii. Assess patients' risk of acquiring altitude illness and body weight (kg)
   iii. Review signs/symptoms of altitude illness, discuss safe ascent rates and tips for acclimating to higher altitudes (alcohol abstinence, limited activity)
   iv. Screen for contraindications
      1. AcetaZOLAMIDE
         a. Hypersensitivity to acetazolamide or sulfonamides

b. Prophylaxis
   i. Consult the CDC Yellow Book for list of risk factors for AMS. If risk factors are present and warrant prophylaxis:
      1. *AcetaZOLAMIDE (Diamox®)*
         Adult Dosing: Acetazolamide 125 mg; 250 mg if >100 kg
         - Take 1 dose twice daily starting 24 hours before ascent, continuing the first 2 days at elevation, and longer if ascent continues

         Pediatric Dosing:
         2.5 mg/kg/dose every 12 hours before ascent, continuing during ascent, and 2-3 days after highest altitude achieved or upon return (maximum of 125 mg/dose).

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4. **Motion Sickness**
    a. Patient assessment
        i. Review detailed itinerary and identify travel areas of increased risk
        ii. Assess patients' risk of acquiring motion sickness and body weight (kg)
        iii. Review signs/symptoms of motion sickness, discuss tips for reducing motion sickness: being aware of triggers, reducing sensory input
        iv. Screen for contraindications
    b. Prophylaxis
        i. Consult the CDC Yellow Book for list of risk factors for motion sickness. If risk factors present and warrant pharmacologic prevention:
        ii. Adults
            1. **First-line**: *Scopolamine transdermal patches* (age <18 requires prescription from PCP)
               • Apply 1 patch (1.5 mg) to hairless area behind ear at least 4 hours prior to exposure; replace every 3 days as needed

AND/OR

            2. **Second-line:**
                a. *Promethazine 25mg Tablets:* Take one tablet by mouth 30 – 60 minutes prior to exposure and then every 12 hours as needed
                b. *Promethazine 25mg Suppositories:* Unwrap and insert one suppository into the rectum 30-60 minutes prior to exposure and then every 12 hours as needed
                c. *Meclizine 12.5-25mg* (OTC/Rx):
                   Take 25 to 50 mg 1 hour before travel, repeat dose every 24 hours if needed

        iii. Pediatrics
            1. **First-line**:
                a. 7-12 years old
                    - *DimenhyDRINATE (OTC Dramamine®)* 1-1.5mg/kg/dose*:* Take one dose 1 hour before travel and every 6 hours during the trip (maximum 25 per dose)
                    - *DiphenhydrAMINE (OTC Benadryl®)* 0.5-1mg/kg/dose*:* Take one dose 1 hour before travel and every 6 hours during the trip (maximum 25 mg per dose)
                b. ≥ 12 years old
                    - *Meclizine 12.5-25mg* (OTC/Rx): Take 25 to 50 mg 1 hour before travel, repeat dose every 24 hours if needed

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Travel Medications - Assessment and Treatment Care Pathway

Screen for Protocol Contraindications:

Malaria Prophylaxis

1. Chloroquine
   c. Age < 7 years old
   d. Hypersensitivity to chloroquine, 4-aminoquinolone compounds, or any component of the formulation
   e. Presence of retinal or visual field changes of any etiology
2. Hydroxychloroquine
   a. Age < 7 years old
   b. Hypersensitivity to hydroxychloroquine, 4 aminoquinoline derivatives, or any component of the formulation
3. Atovaquone/proguanil
   a. Age < 7 years old
   b. Weight < 5 kg
   c. Hypersensitivity to atovaquone, proguanil or any component of the formulation
   d. Prophylactic use in severe renal impairment (CrCl < 30 mL/min)
   e. Cannot be used by women who are pregnant or breastfeeding a child that weighs < 5 kg
4. Doxycycline
   a. Age < 8 years old
   b. Hypersensitivity to doxycycline, other tetracyclines
   c. Pregnancy
   d. Breast-feeding
5. Mefloquine
   a. Age < 7 years old
   b. Hypersensitivity to mefloquine, related compounds (i.e. quinine and quinidine)
   c. Prophylactic use in patients with history of seizures or psychiatric disorder (including active or recent history of depression, generalized anxiety disorder, psychosis, schizophrenia, or other major psychiatric disorders)
   d. Not recommended for people with cardiac conduction abnormalities

Traveler's Diarrhea

1. Loperamide
   a. Age < 7 years old
   b. Hypersensitivity to loperamide or any component of the formulation
   c. Abdominal pain without diarrhea
   d. Acute dysentery
   e. Acute ulcerative colitis
   f. Bacterial enterocolitis (caused by *Salmonella, Shigella, Campylobacter)*
   g. Pseudomembranous colitis associated with broad-spectrum antibiotic use
   h. OTC—do not use if stool is bloody or black
2. Azithromycin
   a. Age < 18 years old will require a prescription from a PCP
   b. Hypersensitivity to azithromycin, erythromycin or other macrolide antibiotics
   c. History of cholestatic jaundice/hepatic dysfunction associated with prior azithromycin use

Altitude Illness

1. AcetaZOLAMIDE
   a. Age < 7 years old
   b. Marked hepatic disease or insufficiency
   c. Decreased sodium and/or potassium levels
   d. Adrenocortical insufficiency
   e. Cirrhosis

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f. Hyperchloremic acidosis
g. Severe renal dysfunction or disease
h. Long term use in congestive angle-closure glaucoma
i. Hypersensitivity to acetazolamide or any excipients in the formulation. Since acetazolamide is a sulfonamide derivative, cross sensitivity between acetazolamide, sulfonamides and other sulfonamide derivatives is possible.

Motion Sickness

1. Scopolamine
    a. Age < 18 years old will require a prescription from a PCP
    b. Hypersensitivity to scopolamine
    c. Glaucoma or predisposition to narrow-angle glaucoma
    d. Paralytic ileus
    e. Prostatic hypertrophy
    f. Pyloric obstruction
    g. Tachycardia secondary to cardiac insufficiency or thyrotoxicosis
2. Promethazine
    a. Age < 7 years old
    b. Hypersensitivity to promethazine or other phenothiazines (i.e. prochlorperazine, chlorproMAZINE, fluPHENAZine, perphenazine, etc)
    c. Treatment of lower respiratory conditions (e.g., asthma)
3. Meclizine
    a. Age < 12 years old
    b. Hypersensitivity to meclizine
4. DimenhyDRINATE
    a. Age < 7 years old
    b. Hypersensitivity to dimenhyDRINATE or any component of the formulation
5. DiphenhydrAMINE
    a. Age < 7 years old
    b. Hypersensitivity to diphenhydrAMINE or other structurally related antihistamines or any component of the formulation
    c. Breastfeeding

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Travel Medications - Prescription

Optional-May be used by pharmacy if desired

Patient Name:	Date of birth:
Address:	
City/State/Zip Code:	Phone number:
Patient Weight (kg):	

Rx

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____

- Directions: ____
- Quantity: _______ + 0 refills

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____

- Directions: ____
- Quantity: _______ + 0 refills

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____

- Directions: ____
- Quantity: _______ + 0 refills

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____

- Directions: ____
- Quantity: _______ + 0 refills

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____

- Directions: ____
- Quantity: _______ + 0 refills

Written Date: ______________________________________

Prescriber Name:________________________________Prescriber Signature: ___________________________

Pharmacy Address:______________________________________Pharmacy Phone: ______________________

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Provider Notification
Travel Medications

Pharmacy Name:_________________________ Pharmacist Name: __________________________________
Pharmacy Address:____
Pharmacy Phone:________________________ Pharmacy Fax: _____________________________________

Patient Name:____ DOB: ____/_____/_____ Age:_____

Healthcare Provider:____________________________________ Phone: (____)_____-________ Fax: (____)_____-________

Your patient was seen at our pharmacy on ____/____/____ for a professional travel consultation. During this visit, we carefully reviewed the patient's medical history, prescription history, and lifestyle factors to ensure the safety of all medications prescribed and vaccines administered. Upon review it was determined that the patient could benefit from prescription/vaccine therapy. The following prescription(s) and/or vaccines were provided to your patient:

☐ **Medications Prescribed**

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____
- Directions: ____
- Quantity: _______ + 0 refills

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____
- Directions: ____
- Quantity: _______ + 0 refills

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____
- Directions: ____
- Quantity: _______ + 0 refills

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness

☐ **Drug:** ____
- Directions: ____
- Quantity: _______ + 0 refills

☐ **Vaccines Administered**

Vaccines							
Recommended	Given	Declined	Dose #	Recommended	Given	Declined	Dose#
☐ Cholera	☐	☐		☐ Polio	☐	☐	
☐ COVID-19	☐	☐		☐ PPSV23	☐	☐	
☐ Hepatitis A/B	☐	☐		☐ Rabies	☐	☐	
☐ Hepatitis A	☐	☐		☐ RSV	☐	☐	
☐ Hepatitis B	☐	☐		☐ Shingles	☐	☐	
☐ Hib	☐	☐		☐ Td/Tdap	☐	☐	
☐ HPV	☐	☐		☐ Typhoid IM	☐	☐	
☐ Influenza	☐	☐		☐ Typhoid PO	☐	☐	
☐ Japanese Encephalitis	☐	☐		☐ Varicella	☐	☐	
☐ Meningococcal	☐	☐		☐ Yellow Fever	☐	☐	
☐ PCV 15/20	☐	☐		☐ Other: _____________	☐	☐	

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☐ **Medications and/or Vaccines NOT provided at our pharmacy, because:**

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine.

- ☐ **Drug/Vaccine:** ____
- ☐ **Reason for Referral:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine.

- ☐ **Drug/Vaccine:** ____
- ☐ **Reason for Referral:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine.

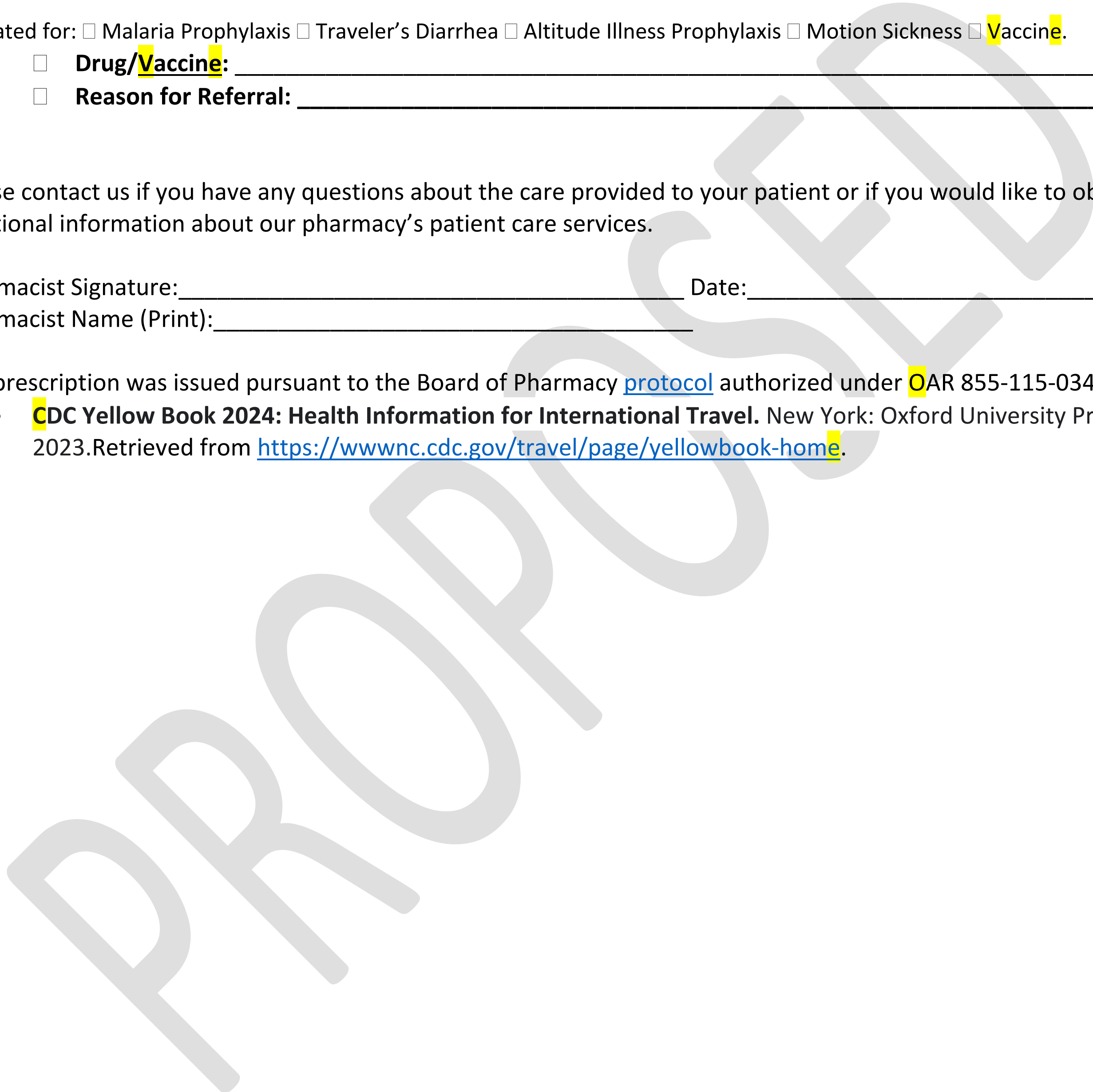
- ☐ **Drug/Vaccine:** ____
- ☐ **Reason for Referral:** ____

Please contact us if you have any questions about the care provided to your patient or if you would like to obtain additional information about our pharmacy's patient care services.

Pharmacist Signature:______________________________________ Date:____________________________
Pharmacist Name (Print):_____________________________________

The prescription was issued pursuant to the Board of Pharmacy protocol authorized under OAR 855-115-0345.

- **CDC Yellow Book 2024: Health Information for International Travel.** New York: Oxford University Press; 2023.Retrieved from https://wwwnc.cdc.gov/travel/page/yellowbook-home.



Patient Visit Summary

Travel Medications

Pharmacy Name:________________________________ Pharmacist Name:______________________________________

Pharmacy Address:____

Pharmacy Phone: ____________________________ Pharmacy Fax: ____________________________

Today, on ____/____/____ , you were seen by Pharmacist, ________________________________ for a professional travel consultation.

☐ **You were provided** the following travel medications and/or vaccines:

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____

-- and/or --

☐ You were **not able to receive** the following travel medications and/or vaccines today, and *must consult with a primary care provider for additional evaluation* prior to receiving services, because:

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine.
☐ **Drug/Vaccine:** ____
☐ **Reason for Referral:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____
☐ **Reason for Referral:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____
☐ **Reason for Referral:** ____

Indicated for: ☐ Malaria Prophylaxis ☐ Traveler's Diarrhea ☐ Altitude Illness Prophylaxis ☐ Motion Sickness ☐ Vaccine
☐ **Drug/Vaccine:** ____
☐ **Reason for Referral:** ____

PROPOSED