CLINIQUE SANTÉ 360°

Travel Information form

DOSSIER # ____________

PATIENT IDENTITY		
Last name :		Date of birth:
First name:		Sex : ☐ Men ☐ Women ☐ Other
Quebec health insurance board (RAMQ) :		Expiration date :
Cell phone :	Home :	Work :
E-mail :		
Address :		Flat :
City :		Zip code :
Height:	Weight : ☐ kg ☐ lbs	Nationality :
Profession :		☐ Retired ☐ Student

LEGAL REPRESENTANT FOR PATIENT UNDER 14 YEARS OLD	
First and last name :	
E-mail :	
Relationship :	☐ Mother ☐ Father ☐ Familly member ☐ Legal guardian ☐ Other :
Are the parents separated? ☐ YES / ☐ NO	

HOW DID YOU HEAR ABOUT OUR CLINIC ?			
☐ Relatives	☐ Facebook	☐ Web search	☐ Local advertising
☐ Other healthcare professionnal	☐ Instagram	☐ Website as Clic-Santé	☐ Radio / newspaper / TV
Referred by :	Do you consent to receive our newsletter by email ? ☐ YES / ☐ NO		

PATIENT'S HEALTHCARE PROFESSIONALS			
Doctor :		Fax :	
Hospital/Clinic :		Phone :	
Pharmacy :		**Fax :**	
Pharmacy address :		Phone :	

CONFIDENTIAL MEDICAL INFORMATION	
To help us make a better assessment of your condition, please fill out this form on your state of heath to the best of your knowledge.	
Allergies / Intolerances and reactions caused:	
Medications taken daily :	
Antibiotic taken in the last 3 months:	

MEDICAL INFORMATIONS		
Do you currently have a fever or an infection? ☐ YES / ☐ NO		
Do you suffer or have you ever suffered from these conditions?		☐ No medical condition
☐ Epilepsy ou convulsion	☐ Cardiovascular disorders	☐ Depression / anxiety
☐ Psoriasis	☐ Thymus disease	☐ Diabeties
☐ Breathing difficulties	☐ Liver disease	☐ Bleeding disorders
☐ Inflammatory bowel disease	☐ Immunodeficiency (Cancer, VIH, Cortisone, graft)?	
☐ Other chronic medical condition :		

PREGNANCY	
Are you pregnant? ☐ YES / ☐ NO / ☐ DO NOT KNOW	How many weeks :
Do you plan on being pregnant in the next 3 months? ☐ YES / ☐ NO	
IMMUNISATION	
Did you receive vaccines at a young age? ☐ YES / ☐ NO	In the last 10 years? ☐ YES / ☐ NO
Which ones ?	
Have you ever had any allergic reactions following a vaccine? ☐ YES / ☐ NO	
Which vaccin :	Reaction :
TRIP	
Destination(s) :	
Type of trip: ☐ Plane ☐ Cruise ☐ Bus / Camping-car / Car ☐ Other :	
Departure date :	Duration of the trip:
Where will you stay (hotel, camping, etc)?	
What activities do you plan?	
Are you travelling accompanied? ☐ Alone ☐ In couple ☐ In group ☐ Family	

As ☐ Patient ☐ Father/Mother ☐ Family member ☐ Guardian , I, the undersigned, ____________________________________

certify that the information noted in this document is accurate and/or filled to the best of my knowledge.

CONSENT

By signing this document, you acknowledge that you have understood and accepted our general terms of use and our privacy policy, available on our website and at the reception of our clinics.
General terms of use: www.cliniquesante360.com/conditions-et-modalites
Privacy policy: www.cliniquesante360.com/politique-de-confidentialite

You also consent to the following points:

1. You authorize Clinic Santé 360 and its medical partners to collect, store, modify, or update information deemed necessary for the patient's health monitoring.
2. You consent to the exchange of any medical information between the nurse, pharmacist, and the doctor or any other healthcare professional involved in the patient's health monitoring.
3. You authorize the taking of images or videos of the patient, in whole or in part, to be transferred to their medical record and shared with the medical staff responsible for their monitoring as needed.
4. You understand that the transmission of patient information (record, notes, results, etc.) to a third party not working in collaboration with Clinic Santé 360 (treating physician, insurance company, etc.) will be subject to a different consent form and possibly fees.
5. You understand that in accordance with applicable laws, you may access the patient's information and request corrections or deletions as needed by submitting a written request.

Signature : ____ **Date :** ____