

# INITIAL REFUGEE HEALTH ASSESSMENT FORM

<b>ALIEN #:</b>		<b>DATE OF HEALTH ASSESSMENT:</b>	
		MM   DD   YYYY	
<b>PATIENT'S NAME: LAST, FIRST, MIDDLE</b>		<b>SEX:</b>	<b>DATE OF BIRTH:</b>
		<input type="checkbox"/> M <input type="checkbox"/> F	MM   DD   YYYY
<b>STREET ADDRESS:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>RACE (PLEASE CHECK ALL THAT APPLY):</b>	<b>ETHNIC ORIGIN:</b>	<b>COUNTRY OF BIRTH:</b>	<b>U.S. ENTRY DATE:</b>
<input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> WHITE	<input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC		MM   DD   YYYY
	<b>LANGUAGE INTERPRETATION NEEDED?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>OVERSEAS TB CLASS A, B1, OR B2 STATUS? (REVIEW OVERSEAS DOCUMENTS)</b>
	PREFERRED LANGUAGE _____		<input type="checkbox"/> NONE
	LANGUAGE USED DURING ASSESSMENT _____		<input type="checkbox"/> YES, SPECIFY _____

### IMMUNIZATIONS

1. REVIEW ALL OVERSEAS DOCUMENTS FOR PREVIOUS VACCINATIONS.
2. IF TITERS DONE: CIRCLE "Y" IF IMMUNE, "N" IF NOT IMMUNE, "I" IF INDETERMINATE.
3. FOR POLIO: NUMBER OF OVERSEAS DOSES ON OVERSEAS DOCUMENTS (1, 2, 3, NONE).
4. IF VACCINATED IN U.S., NOTE FULL DATE (MM/DD/YYYY)

	IS PERSON IMMUNE?	MM/DD/YYYY	MM/DD/YYYY		MM/DD/YYYY
MEASLES	Y   N   I			HUMAN PAPILLOMA VIRUS	
MUMPS	Y   N   I			ZOSTER (SHINGLES)	
RUBELLA	Y   N   I			HAEMOPHILUS INFLUENZA TYPE B	
DIPHTHERIA, TETANUS, AND PERTUSSIS	Y   N   I			PNEUMOCOCCAL	
DIPHTHERIA – TETANUS	Y   N   I			INFLUENZA	
POLIO	1   2   3   NONE			MENINGOCOCCAL CONJUGATE	
HEPATITIS B	Y   N   I				
HEPATITIS A	Y   N   I				
VARICELLA	Y   N   I				

IMMUNIZATION CATCH-UP SCHEDULE BEGUN?    YES    NO

### TUBERCULOSIS SCREENING & DIAGNOSIS -- REPORT TESTS DONE IN U.S. ONLY

<p><b>DATE OF TEST</b></p> <p><b>TUBERCULIN SKIN TEST (TST)</b></p> <p style="text-align: center;">MM   DD   YYYY</p> <p><b>MM INDURATION</b></p> <p style="text-align: center;">_____</p>	<p><b>TEST RESULTS: TST</b></p> <p><input type="checkbox"/> POSITIVE    <input type="checkbox"/> NEGATIVE    <input type="checkbox"/> PENDING</p>	<p><b>TUBERCULOSIS DIAGNOSIS (MUST CHECK ONE)</b></p> <p><input type="checkbox"/> NO TB INFECTION OR DISEASE</p> <p><input type="checkbox"/> LATENT TB INFECTION (LTBI)</p> <p>REFERRED FOR FOLLOW-UP?   <input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p>APPOINTMENT DATE: _____</p> <p style="text-align: center;">MM   DD   YYYY</p> <p>LTBI TREATMENT STARTED?</p> <p><input type="checkbox"/> YES   <input type="checkbox"/> NO   <input type="checkbox"/> UNKNOWN</p> <p><input type="checkbox"/> ACTIVE DISEASE – REFERRED FOR FOLLOW-UP</p> <p>APPOINTMENT DATE: _____</p> <p style="text-align: center;">MM   DD   YYYY</p> <p><input type="checkbox"/> PENDING, FOLLOW-UP NEEDED</p>
<p><b>INTERFERON-GAMMA RELEASE ASSAYS (IGRA)</b></p> <p style="text-align: center;">MM   DD   YYYY</p> <p><b>IGRA TYPE:</b></p> <p><input type="checkbox"/> QFT    <input type="checkbox"/> T-SPOT</p>	<p><b>TEST RESULTS: IGRA</b></p> <p><input type="checkbox"/> POSITIVE    <input type="checkbox"/> NEGATIVE    <input type="checkbox"/> PENDING</p>	
<p><b>CHEST X-RAY: ** REPORT ONLY X-RAY DONE IN U.S.</b></p> <p style="text-align: center;">MM   DD   YYYY</p>	<p><b>TEST RESULTS: CXR</b></p> <p><input type="checkbox"/> NORMAL    <input type="checkbox"/> ABNORMAL    <input type="checkbox"/> PENDING</p> <p><input type="checkbox"/> REFERRED FOR CHEST X-RAY</p>	

### HEPATITIS B & C SCREENING (DRAW BLOOD FIRST, THEN VACCINATE)

**HBV**

HBsAg     NEGATIVE     POSITIVE [IF POSITIVE, PATIENT IS INFECTIOUS]     INDETERMINATE     RESULTS PENDING    REFERRED FOR FOLLOW-UP?    YES    NO

ANTI-HBs     NEGATIVE     POSITIVE [IF POSITIVE, PATIENT IS IMMUNE]     INDETERMINATE     RESULTS PENDING    APPOINTMENT DATE: \_\_\_\_\_

ANTI-HBc     NEGATIVE     POSITIVE     INDETERMINATE     RESULTS PENDING    style="text-align: center;">MM | DD | YYYY

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**HCV (ONLY FOR REFUGEES IN HIGH-RISK GROUPS. SEE CDC GUIDELINES)**     NEGATIVE     POSITIVE     INDETERMINATE     RESULTS PENDING

# INITIAL REFUGEE HEALTH ASSESSMENT FORM

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Released 1/25/2013

PATIENT'S NAME: LAST, FIRST, MIDDLE

## HIV/ SEXUALLY TRANSMITTED INFECTIONS/ DISEASES

**HIV** (TEST ALL PERSONS 13-64 YEARS OF AGE: NO OVERSEAS HIV TESTS ARE GIVEN AS OF 2010. SEE CDC GUIDELINES FOR SCREENING CHILDREN)

NEGATIVE  POSITIVE IF POSITIVE, FOLLOW-UP APPOINTMENT DATE: MM | DD | YYYY  PENDING  NOT DONE

**SYPHILIS** (TEST, REGARDLESS OF OVERSEAS RESULT. TEST IS ROUTINE FOR REFUGEES ≥15 YEARS OF AGE)

**VDRL/RPR:**  NEGATIVE  POSITIVE  PENDING  NOT DONE

**EIA:**  NEGATIVE  POSITIVE  PENDING  NOT DONE

IF POSITIVE, CONFIRMATORY TEST (TPPA, FTA, ABS) DONE?  YES  NO

IF EIA POSITIVE, WERE VDRL/RPR AND/OR OTHER CONFIRMATORY TEST(S) DONE?  YES  NO

TREATED?  YES  NO  REFERRED

TREATED?  YES  NO  REFERRED

**CHLAMYDIA** (Women up to 26 years old; or older with risk factors.)  NEGATIVE  POSITIVE  PENDING  NOT DONE

**GONORRHEA** (For specific groups – see CDC guidelines)  NEGATIVE  POSITIVE  PENDING  NOT DONE

## LABORATORY TESTS; LEAD SCREENING

**URINALYSIS DONE?**  YES  NO **SERUM CHEMISTRY DONE?**  YES  NO **CHOLESTEROL DONE?**  YES  NO

**LEAD SCREENING** (TEST ALL CHILDREN 6 MOS. TO 17 YRS. OLD)  YES  NO  RESULTS PENDING RESULT (#): \_\_\_\_\_  VENOUS  CAPILLARY

**CBC WITH DIFFERENTIAL DONE?**  YES  NO IF NOT DONE, REASON? \_\_\_\_\_

A. WAS EOSINOPHILIA PRESENT?  YES  NO B. IF EOSINOPHILIA PRESENT, REFERRED?  YES  NO APPOINTMENT DATE: MM | DD | YYYY

## INTESTINAL PARASITES & MALARIA SCREENING (NOTE: CDC PROTOCOLS ARE BASED ON OVERSEAS TREATMENT)

**U.S. PRESUMPTIVE TREATMENT GIVEN?** **SCHISTOSOMA**  YES  NO **STRONGYLOIDES**  YES  NO REFERRED FOR FOLLOW-UP?  YES  NO

### TESTING FOR PARASITES

**STOOL SPECIMEN (OVA & PARASITES)**  YES  NO  RESULTS PENDING  NO PARASITES FOUND  PARASITES FOUND \_\_\_\_\_

**SEROLOGY TEST**  YES  NO  RESULTS PENDING  SCHISTOSOMA  NEGATIVE  POSITIVE; TREATED?  YES  NO  TEST RESULT INDETERMINATE  STRONGYLOIDES  NEGATIVE  POSITIVE; TREATED?  YES  NO  TEST RESULT INDETERMINATE

**MALARIA SCREENING**  YES  NO  RESULTS PENDING  NO MALARIA SPECIES FOUND  MALARIA SPECIES FOUND \_\_\_\_\_

## MENTAL HEALTH SCREENING

**WAS A U.S. MENTAL HEALTH SCREENING PERFORMED?**  YES  NO REFERRED FOR FOLLOW-UP?  YES  NO APPOINTMENT DATE: MM | DD | YYYY

### OTHER SCREENINGS CONDUCTED:

DENTAL  YES  NO  PENDING  REFERRED  
HEARING  YES  NO  PENDING  REFERRED  
VISION  YES  NO  PENDING  REFERRED  
NUTRITION/VITAMIN LEVELS  YES  NO  PENDING  REFERRED  
PREGNANCY  YES  NO  PENDING  REFERRED

### OTHER REFERRALS (CHECK ALL THAT APPLY):

PRIMARY CARE  INFECTIOUS DISEASE  HIV/STI/STD  
 WOMEN'S HEALTH  NEWBORN SCREENING  PRENATAL CARE  
 NUTRITION/VITAMINS  HYPERTENSION  DIABETES  
 HEALTH EDUCATION  PARASITOLOGY  PAIN

OTHER: \_\_\_\_\_

### COMMENTS / OTHER CONCERNS:

PHYSICIAN'S NAME: LAST, FIRST

FACILITY NAME:

ADDRESS: (STREET, CITY, STATE, ZIP)

TELEPHONE:

FAX:

PERSON COMPLETING REPORT

DATE OF THIS REPORT:

MM | DD | YYYY

PLEASE SEND COMPLETED FORM TO: DEPARTMENT OF PUBLIC HEALTH, REFUGEE AND IMMIGRANT HEALTH PROGRAM, 410 CAPITOL AVE. MS#11TUB, P.O. BOX 340308, HARTFORD, CT 06134-0308; CONFIDENTIAL FAX: 860-509-7743