

INITIAL REFUGEE HEALTH ASSESSMENT FORM

ALIEN #:		DATE OF HEALTH ASSESSMENT:	
		MM DD YYYY	
PATIENT'S NAME: LAST, FIRST, MIDDLE		SEX:	DATE OF BIRTH:
		<input type="checkbox"/> M <input type="checkbox"/> F	MM DD YYYY
STREET ADDRESS:	CITY:	STATE:	ZIP:
RACE (PLEASE CHECK ALL THAT APPLY):	ETHNIC ORIGIN:	COUNTRY OF BIRTH:	U.S. ENTRY DATE:
<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
	LANGUAGE INTERPRETATION NEEDED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	OVERSEAS TB CLASS A, B1, OR B2 STATUS? (REVIEW OVERSEAS DOCUMENTS)
	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>DATE OF TEST</p> <p>TUBERCULIN SKIN TEST (TST)</p> <p style="text-align: center;">MM DD YYYY</p> <p>MM INDURATION</p> <p style="text-align: center;">_____</p>	<p>TEST RESULTS: TST</p> <p><input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> PENDING</p>	<p>TUBERCULOSIS DIAGNOSIS (MUST CHECK ONE)</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>INTERFERON-GAMMA RELEASE ASSAYS (IGRA)</p> <p style="text-align: center;">MM DD YYYY</p> <p>IGRA TYPE:</p> <p><input type="checkbox"/> QFT <input type="checkbox"/> T-SPOT</p>	<p>TEST RESULTS: IGRA</p> <p><input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> PENDING</p>	
<p>CHEST X-RAY: ** REPORT ONLY X-RAY DONE IN U.S.</p> <p style="text-align: center;">MM DD YYYY</p>	<p>TEST RESULTS: CXR</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

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

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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