**INITIAL REFUGEE HEALTH ASSESSMENT FORM**

**PATIENT'S NAME:** LAST, FIRST, MIDDLE

**STREET ADDRESS:**

**HOME TELEPHONE:**

**RACE (PLEASE CHECK ALL THAT APPLY):**
- AMERICAN INDIAN/ALASKA NATIVE
- ASIAN
- BLACK OR AFRICAN AMERICAN
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- WHITE

**ETHNIC ORIGIN:**

**CITY:**

**STATE:**

**ZIP:**

**OVERSEAS TB CLASS A, B1, OR B2 STATUS?** (REVIEW OVERSEAS DOCUMENTS)

**DATE OF BIRTH:**

**U.S. ENTRY DATE:** MM DD YYYY

**DATE OF HEALTH ASSESSMENT:** MM DD YYYY

**SEX:**
- M
- F

**LANGUAGE INTERPRETATION NEEDED?**
- YES
- NO

**OVERSEAS TB CLASS A, B1, OR B2 STATUS? (REVIEW OVERSEAS DOCUMENTS)**

**LANGUAGE USED DURING ASSESSMENT**

**PREFERRED LANGUAGE**

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**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)

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>Y</th>
<th>N</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEASLES</td>
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<tr>
<td>MUMPS</td>
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<tr>
<td>RUBELLA</td>
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<tr>
<td>DIPHTHERIA, TETANUS, AND PERTUSSIS</td>
<td></td>
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<tr>
<td>DIPHTHERIA – TETANUS</td>
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<tr>
<td>POLIO</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td></td>
<td></td>
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<tr>
<td>HEPATITIS A</td>
<td></td>
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<tr>
<td>VARICELLA</td>
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</tbody>
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**TUBERCULOSIS SCREENING & DIAGNOSIS -- REPORT TESTS DONE IN U.S. ONLY**

<table>
<thead>
<tr>
<th>TUBERCULOSIS SCREENING &amp; DIAGNOSIS</th>
<th>DATE OF TEST</th>
<th>MM/DD/YYYY</th>
<th>TEST RESULTS: TST</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TUBERCULIN SKIN TEST (TST)</td>
<td></td>
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<tr>
<td>INTERFERON-GAMMA RELEASE ASSAYS (IGRA)</td>
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<tr>
<td>CHEST X-RAY: <strong>REPORT ONLY X-RAY DONE IN U.S.</strong></td>
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**TUBERCULOSIS DIAGNOSIS (MUST CHECK ONE)**

- NO TB INFECTION OR DISEASE
- LATENT TB INFECTION (LTBI)

**LTBI TREATMENT STARTED?**
- YES
- NO
- UNKNOWN

**ACTIVE DISEASE – REFERRED FOR FOLLOW-UP**

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

<table>
<thead>
<tr>
<th>HBV</th>
<th>Y</th>
<th>N</th>
<th>I</th>
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<tbody>
<tr>
<td>HBsAg</td>
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<td></td>
<td></td>
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<tr>
<td>Anti-HBs</td>
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<td></td>
<td></td>
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<tr>
<td>Anti-HBC</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCV</th>
<th>Y</th>
<th>N</th>
<th>I</th>
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<tbody>
<tr>
<td>(ONLY FOR REFUGEES IN HIGH-RISK GROUPS. SEE CDC GUIDELINES)</td>
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</tbody>
</table>
## 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)

- [ ] Negative
- [ ] Positive
- [ ] Pending
- [ ] Not done

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**Laboratory Tests: Lead Screening**

- [ ] Urinalysis done?
- [ ] Serum chemistry done?
- [ ] Cholesterol done?

**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 & Parases)
  - [ ] Yes
  - [ ] No
  - [ ] Results pending
  - [ ] No parasites found
  - [ ] Parasites found: ________________________________

- [ ] Serology test
  - [ ] 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: ____________

## Other Screenings Conducted:

<table>
<thead>
<tr>
<th>Screening</th>
<th>Yes</th>
<th>No</th>
<th>Pending</th>
<th>Referred</th>
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</thead>
<tbody>
<tr>
<td>Dental</td>
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<tr>
<td>Hearing</td>
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<tr>
<td>Vision</td>
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<tr>
<td>Nutrition/Vitamin Levels</td>
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<tr>
<td>Pregnancy</td>
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</tbody>
</table>

## 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:

- ________________________________

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**Physician's Name: Last, First**

**Facility Name:**

**Address: (Street, City, State, Zip)**

**Telephone:**

**Fax:**

**Person Completing Report**

**Date of this Report:**

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**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