



REFUGEE HEALTH ASSESSMENT TEMPLATE

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Background

The Refugee Health Assessment Template is intended to provide a sample form to collect information during the domestic health exam for newly arriving refugees. This form is part of a broader effort to standardize the refugee health assessment and screening practices. The Refugee Health Assessment Technical Guide provides details regarding each area of the health assessment and links to resources.

The Health Assessment Template was designed to be a tool for clinicians during the domestic health screening. It is also a data collection tool. Some areas of the form are intended for primarily clinician use while others may also be used for data analysis. Where there is overlap between the Refugee Health Data Dictionary and the Health Assessment Template, values have been standardized.



Refugee Health Assessment Template

Review Overseas Medical Documents See Section 1, Refugee Medical Screening Technical Guide (Technical Guide)			
Name (last, first, middle):		Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Alien #	Family case file number	Medicaid #	SSN
Country of Birth	Country of Origin	Prior Country of Residence	Refugee Camp
Resettlement agency	US Arrival Date		US zip code
Class A status: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes (requires approved waiver for US entry & immediate follow-up upon arrival)		Class B TB status: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes (requires follow-up soon after arrival) ➔ Class <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3	
Clinic Visit(s) for screening: Date of screening visit #1: _____ Date of screening visit #2: _____ Date of screening visit #3: _____		Class B Other: <input type="checkbox"/> No <input type="checkbox"/> Yes (requires follow-up soon after arrival) If yes, specify: _____	
Primary spoken language:		Secondary spoken language:	
Interpretation (NOTE: Family and friends not recommended as interpreters) Was an interpreter used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not needed <input type="checkbox"/> Unknown If yes, type of interpreter used: <input type="checkbox"/> In person <input type="checkbox"/> Telephonic <input type="checkbox"/> Video conference <input type="checkbox"/> Other If yes, language: _____		Interpreter name: _____	

Consent for Treatment: NOTE: Individual clinics have established language for consent that meets state requirements. Suggest inserting this language here or removing this section if separate consent process is used.

Vital Signs See Section 2, Technical Guide			
Height (in.)	Weight (lbs.)	Head Circumference (cm)	BMI
Pulse	Blood Pressure	Respirations	Temperature (F°)
Vision Screening OD ___/20 OS ___/20 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> Not done		Hearing Screening <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> Not done	

Past Medical History ^β See Section 3, Technical Guide			
Current Medications <input type="checkbox"/> None <input type="checkbox"/> Yes (list / attach) _____			
Medication Allergies <input type="checkbox"/> None <input type="checkbox"/> Yes (list / attach) _____		Herbal/Traditional treatments <input type="checkbox"/> None <input type="checkbox"/> Yes (list / attach) _____	
Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Integumentary	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health Concern	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genitourinary	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not Done EDD: _____ LMP: _____ G: _____ P: _____ AB: _____		Drug use <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (ie, betel nut use, khat) _____			

Review of Systems ^β [See Section 3, Technical Guide](#)

	Normal	Abnormal	Not done	Unknown	Description
Constitutional Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gynecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hematologic, Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic, Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Physical Exam ^β [See Section 4, Technical Guide](#)

[for example: *Pallor? Hepatosplenomegaly? Lymphadenopathy? Nutritional status?*]

(*NL, normal; *A, abnormal)	*NL	*A	Description	*NL	*A	Description
Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
Neck	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Extremities
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Skin
Back	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal
Breasts	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Neurological
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Oral/dental exam

Preventive Health Interventions [See Section 5, Technical Guide](#)

Urinalysis ^β *Screen for indicators of chronic conditions for any patient old enough to produce a clean catch specimen*

Glycosuria: Negative Positive Not Done Proteinuria: Negative Positive Not Done
Hematuria: Negative Positive Not Done

Pregnancy Test ^β (Urine pregnancy test for all women of childbearing age)

Screened? Yes, _____(date) Negative Positive Not Done

Immunizations ^β Overseas immunizations done [See Section 5.1, Technical Guide](#)

	If titers done, check "Y" if immune, "N" if not immune, "I" if indeterminate	mm/dd/yr	mm/dd/yr	mm/dd/yr	mm/dd/yr	mm/dd/yr	mm/dd/yr
Measles	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I						
Mumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I						
Rubella	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I						
Varicella (VZV)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I						
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I						
Diphtheria-Tetanus (Td, Tdap)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I						
Polio (IPV, OPV)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N						
Hepatitis B (HBV)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I						
Hepatitis A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> I						
Meningococcal conjugate (MCV)							
Haemophilus influenzae type b (Hib)							
Influenza							
Pneumococcal							
Human Papilloma Virus (HPV)							
Zoster (shingles)							

Tuberculosis Screening ^β		See Section 5.3, Technical Guide
Interferon-Gamma Release Assays (IGRAs) <i>NOTE: TST is preferred for testing children aged <5 years old.</i> Was an IGRA performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Test used: <input type="checkbox"/> T-spot <input type="checkbox"/> Quantiferon <input type="checkbox"/> Unknown IGRA Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Borderline <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown	Tuberculin Skin Test (TST) <i>(regardless of BCG history)</i> Was a TST performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Past History of positive TST TST plant date: _____ TST read date: _____ Induration: _____mm TST result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown <input type="checkbox"/> Given, not read	
Chest X-ray – done in U.S. <i>(If TST, IGRA positive, Class B or symptomatic)</i> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Not TB <input type="checkbox"/> Abnormal (consistent with TB). If Abnormal: Miliary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Cavitary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not done <input type="checkbox"/> Declined	Diagnosis (must check one) <input type="checkbox"/> No TB infection or disease <input type="checkbox"/> Latent TB infection (LTBI), <input type="checkbox"/> Old, healed previously treated TB <input type="checkbox"/> Active TB disease – (suspected or confirmed)* <input type="checkbox"/> Pending <input type="checkbox"/> Incomplete evaluation	
Hepatitis B Screening ^β		See Section 5.4, Technical Guide
HBsAg (✓ one) <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done <input type="checkbox"/> Unknown Anti-HBs (✓ one) <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done <input type="checkbox"/> Unknown Anti-HBc (✓ one) <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done <input type="checkbox"/> Unknown Diagnosis (MUST check one) <input type="checkbox"/> Immune (Anti-HBs positive) <input type="checkbox"/> Unvaccinated and susceptible (all negative); vaccinate <input type="checkbox"/> Possible active (HbsAg or Anti-HBc positive), referred to PMD / specialist for follow-up <input type="checkbox"/> Pending		
Syphilis Screening (VDRL/RPR) ^β		See Section 5.5, Technical Guide
<i>Routine testing for syphilis for refugees > 15 years of age. See CDC domestic screening guidelines for specific criteria for children < 15 years of age</i> Syphilis result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Unknown Syphilis confirmatory test result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Unknown If positive, did the person receive treatment for syphilis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred for treatment <input type="checkbox"/> Unknown		
Chlamydia /Gonorrhea Screening ^β		See Section 5.6; 5.7, Technical Guide
<i>(Urine specimen) Chlamydia testing for women ≤ 25 years of age or older with risk factors. See CDC domestic screening guidelines for specifics and other STI's</i> Chlamydia <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Unknown If positive, treated for chlamydia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred for treatment <input type="checkbox"/> Unknown Gonorrhea <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Unknown If positive, treated for gonorrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred for treatment <input type="checkbox"/> Unknown		
HIV Screening ^β		See Section 5.8, Technical Guide
<i>CDC recommends for all persons 13-64 years of age; children <13 years of age should be screened unless the mother's HIV status can be confirmed as negative and the child is otherwise thought to be at low risk of infection.</i> Was HIV testing done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Offered, but refused HIV testing result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Unknown HIV confirmatory test result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Unknown If positive, HIV referral? <input type="checkbox"/> Referred to Infectious Disease specialist <input type="checkbox"/> No <input type="checkbox"/> Unknown		
CBC with Differential ^β		See Section 5.2, Technical Guide
Screened? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes: Eosinophil (absolute) _____ EOS% _____ MCV _____ RDW _____ Hemoglobin _____ Hematocrit _____ Eosinophilia present? <input type="checkbox"/> Yes <input type="checkbox"/> No If eosinophilia was present, referred for further evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

Intestinal Parasite Screening ^β	See Section 5.9, Technical Guide	
<i>Those populations identified as being treated overseas should be assumed to have received such treatment. For up-to-date information on groups being treated see green box at: www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html</i>		
Pre-departure presumptive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If known, specify treatment: _____		
Did the person receive domestic presumptive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown See CDC Figures 1-3 to implement protocol based on specific overseas treatment.		
Serology Test (see population specific recommendations)		
Schistosoma <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Unknown If positive, treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Strongyloides <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Unknown If positive, treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Ova & Parasite Screening		
Was stool ova and parasite screening performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Dates: <input type="checkbox"/> O&P x1 ___/___/___(date) <input type="checkbox"/> O&P x 2 ___/___/___(date)		
Results: <input type="checkbox"/> No parasites found <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/> Pathogenic parasite(s)found; check all that apply below		
<input type="checkbox"/> Ascaris	<input type="checkbox"/> Clonorchis	<input type="checkbox"/> Dientamoeba fragilis
<input type="checkbox"/> Entamoeba histolytica	<input type="checkbox"/> Giardia	<input type="checkbox"/> Hookworm
<input type="checkbox"/> Paragonimus	<input type="checkbox"/> Schistosoma	<input type="checkbox"/> Strongyloides
<input type="checkbox"/> Tapeworm	<input type="checkbox"/> Trichuris	<input type="checkbox"/> Other (specify)
Referral for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No; why not? _____		
Malaria Screening ^β	See Section 5.10, Technical Guide	
<i>Those populations identified as being treated overseas should be assumed to have received such treatment. For up-to-date information on groups being treated see green box at: www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html</i>		
Pre-departure presumptive treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Screened? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Domestic presumptive treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Malaria results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown	
History of malaria exposure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If malaria species found, specify species _____	
Symptoms of malaria <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	Referred for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Lead Screening (<17 years old) ^β	See Section 5.11, Technical Guide	
Screened? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unknown		
↳ If yes: BLL _____		
↳ If elevated, referred for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
NOTE: Re-check all children aged 6 months- 6 years within 3-6 months of arrival, regardless of results of initial lead screen.		
Mental Health Status	See Section 6, Technical Guide	
ARHC recommends using a standardized screening tool such as the Refugee Health Screener-15, the Patient Health Questionnaire-9, or the Hopkins Symptom Checklist when screening refugees for mental health concerns. Please carefully consider the availability of appropriate referral resources and protocols for those who screen positive.		
Does the overseas medical record indicate a diagnosis of mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a specific mental health screening tool being used for this exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
↳ If yes, specify which tool _____		
Screening tool result: _____		
<i>If a specific mental health screening tool is <u>not</u> used, here are some suggested questions to use to inquire about mental status. In the past month have you:</i>		
Had trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Experienced nightmares that interfere with your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Noticed an increase or decrease in your appetite, or unexplained weight change?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Been thinking too much about the past even if you did not want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Been unable to concentrate, remember things, or make decisions?(for example, drifting in/out of conversations, losing track of a story on television, forgetting what you read)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Had thoughts about hurting yourself or others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If the client answers "yes" to any of the above questions, suggest, "It seems like you are having trouble with [specific symptom(s)]. Some people find talking to a counselor can assist with these feelings. Is that something you are interested in?" If the client says,		

“yes,” initiate a referral to appropriate care.

Additional Labs and Screening

[See Section 7, Technical Guide](#)

- [Cancer screening](#)
- [Complete metabolic panel; lipid panel](#) ^β
- [Hepatitis A](#)
- [Hepatitis C](#) ^β
- [Infant metabolic screening in newborns, according to state guidelines](#) ^β
- [Mental Health screening](#)
- [Nutritional screens/ population specific](#) ^β
- [Sickle Cell Anemia](#)
- Specific to Women
- Specific to Children

Referrals (check all that apply)

<input type="checkbox"/> Primary Care	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Emergency/Urgent	<input type="checkbox"/> WIC	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Disability Services
<input type="checkbox"/> Other _____			
Vitamins recommended: <input type="checkbox"/> Multivitamin <input type="checkbox"/> Vitamin D <input type="checkbox"/> Prenatal <input type="checkbox"/> Population specific:			
Date of completion:			
Provider Name / Title:			
Clinic Name:		Phone Number:	

Refugee Health Assessment: Technical Guide

Comprehensive Technical Guides	Basic Screen	Primary Care Services with optional additions	Instructional/procedures
Section 1. Review overseas medical documents			
	X	X	Verify visa status and I-94 card; xerox and keep in file Engage an interpreter; preferably a trained medical interpreter, in person or via telephone. Use family members only as last resort. Review the DS 2053, 3025, 3026, 3024 noting any concerns mentioned
Section 2. Vital signs			
	X	X	<ul style="list-style-type: none"> • Weight • Height • Blood Pressure • Pulse • Temperature • Respiration • BMI / (For children less than 2 years old) • Head circumference (0 - 36 months)
Section 3. Medical history / Review of systems ^B			
www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/guidelines-history-physical.html			
	X	X	History: <ul style="list-style-type: none"> • Injury • Childhood disease • Surgeries/hospitalization • Allergies • Note impairments (cognitive & physical) • Identify indicators of chronic health concerns
	X	X	Review of symptoms, acute concerns
	X	X	Assess current medication : <ul style="list-style-type: none"> • OTC, psychotropic and traditional remedies and treatments • Assess for use of remedies or treatments contraindicated with use of a prescription medication or for products that may contain toxic elements (i.e., lead, arsenic).
	X	X	Evaluate for substance use/abuse
	X	X	Educate: <ul style="list-style-type: none"> • Any general and patient specific identified concerns • U.S. Health care system (how to access) http://www.healthyroadsmedia.org/topics/personalhealth.htm • Health insurance • Primary and preventive medical care • Emergency services, 911, primary care services http://www.healthyroadsmedia.org/topics/emergencies.htm • Oral health and dental care http://www.healthyroadsmedia.org/topics/dental.htm • How to use medications http://www.healthyroadsmedia.org/topics/medicines.htm
	X	X	Vision/ophthalmologic care

Comprehensive Technical Guides	Basic Screen	Primary Care Services with optional additions	Instructional/procedures
Section 4. Physical exam ^β www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/guidelines-history-physical.html			
Complete physical exam	X	X	<ul style="list-style-type: none"> • Make appropriate referrals to primary care or appropriate specialist
	X	X	<ul style="list-style-type: none"> • Test for vision impairment and make appropriate referral
		X	<ul style="list-style-type: none"> • Test for hearing impairment and make appropriate referral
	X	X	<ul style="list-style-type: none"> • Evaluate need for dental referral
		X	<ul style="list-style-type: none"> • Follow up testing and further evaluation of conditions causing abnormal results
X	X	<ul style="list-style-type: none"> • Follow up on all referrals to assure appointments are kept 	
Section 5. Preventive health interventions			
5.1 Immunizations ^β			
	X	X	<ul style="list-style-type: none"> • Record previous vaccines, lab evidence of immunity or hx of disease www.immunize.org/ • Evaluate overseas immunization's records to assess needed updates www.cdc.gov/vaccines/recs/schedules/child-schedule.htm • Give age appropriate vaccines following the ACIP guidelines, complete any series that has been initiated (do not restart a series) www.cdc.gov/vaccines/ • Give priority to giving vaccines needed for children to start school • If unable to provide vaccines, provide appropriate referral to obtain needed immunizations according to the ACIP guidelines • Provide refugee with a record of immunity &/or vaccination, enter into state immunization registry if available.
5.2 General testing www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html#tests	X	X	<ul style="list-style-type: none"> • CBC with differential ^β
		X	<ul style="list-style-type: none"> • Complete metabolic panel ^β
	X	X	<ul style="list-style-type: none"> • Urinalysis to screen for indicators of chronic conditions for any patient old enough to produce a clean catch specimen ^β
	X	X	<ul style="list-style-type: none"> • Urine pregnancy test for women of child bearing age ^β
5.3 Tuberculosis screening ^β www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html	X	X	<ul style="list-style-type: none"> • Evaluate overseas records of TB testing /treatment • Evaluate all refugees for <i>history</i> of tuberculosis, tuberculosis exposure, any treatment • Evaluate for current <i>signs or symptoms</i> of disease (including Class A & B) • Clinically evaluate all refugee arrivals for <i>tuberculosis infection</i> • TST or IGRA (only > 5 years): Chest x-ray for TST > 10 mm or positive IGRA • All patients with TB should be evaluated for HIV infection • All active cases of TB should be reported to state health department • Treat or refer all active TB and LTBI cases
5.4 Hepatitis screening			Hepatitis A and Hepatitis C ^β screening are not recommended at this time
Hepatitis B ^β http://www.cdc.gov/hepatitis/	X	X	<ul style="list-style-type: none"> • Hepatitis B surface antigen (HbsAg) • Hepatitis B surface antibody (anti-Hbs)

Comprehensive Technical Guides	Basic Screen	Primary Care Services with optional additions	Instructional/procedures
			<ul style="list-style-type: none"> • Hepatitis B core antibody (anti-Hbc) • Vaccinate previously unvaccinated and susceptible • Clinically address or refer HbsAg+ for further evaluation and treatment • Assure screening of household contacts
5.5 Syphilis^B www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/sexually-transmitted-diseases.html#syphilis	X	X	VDRL/RPR if >15 years, or < 15 years and if: <ul style="list-style-type: none"> • Sexually active or history of sexual abuse • Has mother who tests or tested positive • Exposure to country endemic for other treponemal subspecies (e.g. yaws, bejal, pinta) • Confirmation testing for positive treponemal tests
5.6 Chlamydia^B www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/sexually-transmitted-diseases.html#chlamydia	X	X	Urine nucleic acid amplification test (NAAT) : <ul style="list-style-type: none"> • Females < 25 years who are sexually active or those with risk factors (e.g. new or multiple partners), • Luecoesterase (LE) positive on urine sample, • Women or children with history of, or at risk, for sexual assault, • Any refugee with symptoms.
5.7 Gonococcus^B www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/sexually-transmitted-diseases.html#gonorrhea	X	X	Urine nucleic acid amplification test (NAAT) : <ul style="list-style-type: none"> • Luecoesterase (LE) positive on urine sample, • Women or children with history of, or at risk, for sexual assault, • Any refugee with symptoms
5.8 HIV^B www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/screening-hiv-infection-domestic.html	X	X	All refugees 13-64 years of age should be screened for HIV, unless they decline (opt out). CDC also encourages screening of all refugees on arrival, including those < 12 and > 64 years of age <ul style="list-style-type: none"> • Refugees should be clearly informed orally or in writing when/if they will be tested for HIV. • A refugee's decision to decline an HIV test should be documented in the medical record • Specific testing for HIV-2 should be conducted for refugees who screen positive for HIV and are native to or have transited through the following countries: Angola, Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Mozambique, Niger, São Tomé, Senegal, Sierra Leone, and Togo. • All HIV-infected refugees should receive competent, culturally sensitive and appropriate counseling in their primary spoken language. • All refugees confirmed to be HIV-infected should be referred for care, treatment, and preventive services.
	X	X	<ul style="list-style-type: none"> • Children <12 years of age should be screened unless the mother's HIV status can be confirmed as negative and the child is otherwise thought to be at low risk of infection (no history of high-risk exposures such as blood product transfusions, early sexual activity, or sexual abuse). <ul style="list-style-type: none"> ◦ If complete risk information is not available, screen • Children < 18 months of age who test positive for HIV antibodies should be tested with DNA or RNA assays. Results of positive antibody tests in this age group can be unreliable because they may detect persistent maternal antibody. • All children born to or breast fed by an HIV-infected

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			<p>mother should receive chemoprophylactic trimethoprim/ sulfamethoxazole beginning at 6 weeks of age and continuing until they are confirmed to be uninfected. http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/screening-hiv-infection-domestic.html - pediatric</p>
	X	X	<p>Identifying and treating HIV-infected pregnant women can prevent HIV infection in their infants.</p> <ul style="list-style-type: none"> All pregnant refugee women should be screened for HIV as part of their routine post arrival and pre-natal medical screening and care. Test pregnant women for HIV during first trimester; if negative, re-test during third trimester.
		X	<ul style="list-style-type: none"> Screening should be repeated 3-6 months following resettlement for refugees who had recent exposure or are at high risk. In geographic areas in which the prevalence of HIV is high, patients who have primary syphilis should be retested for HIV after 3 months if the first HIV test result was negative.
5.9 Intestinal parasites^B www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/intestinal-parasites-domestic.html	X	X	<ul style="list-style-type: none"> Review the overseas medical document for pre-departure treatment Post-arrival screening for intestinal parasites will depend on region of departure and pre-departure presumptive therapy received. For up-to-date information on populations receiving presumptive therapy see CDC website www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html Those populations identified as receiving presumptive treatment overseas should be assumed to have received such treatment..
5.10 Malaria screening^B www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/malaria-guidelines-domestic.html	X	X	<ul style="list-style-type: none"> Review the overseas medical document for pre-departure treatment For up-to-date information on populations receiving presumptive treatment see CDC website All sub-Saharan African refugees, except those with a contraindication (e.g. pregnancy, breastfeeding mothers) are currently receiving pre-departure therapy. Testing or presumptive treatment should be done in: <ul style="list-style-type: none"> Those who did not receive pre-departure therapy Persons with signs or symptoms of malaria infection who originated in a malaria endemic area (link). Refugees arriving from P. falciparum malaria-endemic areas outside sub-Saharan Africa or non-falciparum malaria areas should not receive routine testing or presumptive therapy. Find malaria endemicity information with the online CDC Malaria Map Application.
5.11 Lead screening^B www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html	X	X	<ul style="list-style-type: none"> All refugee children 6 months to 16 years of age Those with elevated BLL require referral for appropriate follow-up.
		X	<ul style="list-style-type: none"> Additional lead test on all children aged 6 mo- 6 yrs within 3-6 months of placement in a permanent residence, regardless of the results of the initial lead screen.

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Section 6. Mental health screening www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html			
Assess general mental health needs	X	X	Screen for signs and symptoms: <ul style="list-style-type: none"> History of torture, trauma, incarceration, sexual assault, maltreatment and acute psychiatric disorders like depression. Capture family history of mental illness include any psychotropic meds, include over the counter and traditional medicine/drug use. If positive refer for full mental health assessment.
Individual additional MH assessment		X	Refer to appropriate mental health specialist to conduct basic mental health assessment to determine any further consultation and treatment.
		X	Identify if there is abuse within the family and educate on child abuse; <ul style="list-style-type: none"> Advise on requirement to disclose and report child abuse offense. (There may be some state specific requirements.)
		X	Screen for caregiver stress; identify the main care giver and inquire about: <ul style="list-style-type: none"> Level of stress; greatest challenge Level of support family offers How is caregiver managing their own stress; client current mood/ limitations/ adjustment; Perspective of household regarding situation
Section 7. General screening and testing for specific populations			
7.1 Lipids http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html#cld_screening		X	Lipid panel, if appropriate
7.2 Vitamin D http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/nutrition-growth.html		X	Test or presumptively treated for Vitamin D deficiency
7.3 Vitamin B12 http://www.cdc.gov/mmwr/preview/mwrhtml/mm6011a4.htm		X	Test for Vitamin B12 (Bhutanese only)
7.4 Infant metabolic screening in newborns	X	X	Follow state specific guidelines
7.5 Cancer screening http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html#cancer_screening		X	<ul style="list-style-type: none"> Cervical (HPV test) Breast Colorectal Prostate (PSA) Maintain high index of suspicion for disease when presenting with hepatitis and H. pylori, or for thyroid cancer with history of radiation exposure (Russian).
7.6 Other: Women		X	<ul style="list-style-type: none"> Evaluate reproductive history for women of child bearing years Evaluate and educate on family planning http://www.healthroadsmedia.org/topics/pregreproduction.htm
	X	X	<ul style="list-style-type: none"> Refer to WIC if appropriate

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7.7 Other: Children		X	<ul style="list-style-type: none"> • Test for age appropriate development in children ages 0 – 20 <ul style="list-style-type: none"> ○ Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program or equivalent development and emotional screening for ages zero to 20. mchb.hrsa.gov/epsdt/overview.html ○ Utilize a standardized tool for assessment www.nlm.nih.gov/medlineplus/ency/article/001928.htm ○ iii. Question parent for any growth & development concerns.
7.8 Other: General	X	X	Assess nutrition issues by doing a brief screen for dairy and food groups, exercise; children and adults as indicated.
	X	X	Report all reportable diagnosis to state health department
	X	X	Report unusual trends or patterns of disease in any population to the state health department and CDC
		X	Refer complex medical cases to appropriate medical case manager
		X	Complete/refer for I-693 (Adjustment of Status or "Green Card Exam") within one year in the USA. USCIS link.