NEW YORK STATE DEPARTMENT OF HEALTH
Refugee Health Program
ESP, Corning Tower, Room 575
Albany, NY 12237-0669

Refugee Health Assessment Form

Instructions: Send the completed form, with the original signature of the Refugee Health Assessment Provider on page 3, to the address above, with a completed State of New York Claim For Payments Form. Questions should be addressed to the Refugee Health Program at (518) 474-4845.

REFUGEE IDENTIFYING INFORMATION

Name: _____ Alien Registration # _____

Date of Birth: ____/____/____ (M M D D Y Y Y Y) Date of U.S. Arrival: ____/____/____ (M M D D Y Y Y Y)

Sex: ☐ Male ☐ Female County: _____

Address: _____ Resettlement Agency: _____

_____ Country of Origin: _____

Telephone: ( ) – Country of Last Residence: _____

Primary Language: _____ Length of Time There: _____

Interpretation Provided By (Name/Agency): _____

OVERSEAS MEDICAL INFORMATION

Overseas Medical Examination Form Reviewed: ☐ Yes ☐ No

Class A or Class B Tuberculosis Identified: ☐ Yes ☐ No If Yes, specify: _____

Other Condition(s) Identified: ☐ Yes ☐ No If Yes, specify: _____

Overseas Chest X-Ray: ☐ Normal ☐ Abnormal ☐ Consistent w/Active TB Date of X-Ray: ____/____/____ (M M D D Y Y Y Y)

MEDICAL HISTORY

Current Symptoms: ☐ Yes ☐ No If Yes, specify: _____

Pertinent History: _____

_____

Pertinent Cultural Health Practices: _____

_____

GENERAL LABORATORY SCREENING See Protocol for testing criteria

	Normal	Abnormal	Not Indicated	Not Done	If Not Done, Reason	Abnormal Findings/Preliminary Diagnosis
CBC with Differential	☐	☐	☐	☐		
Serum Chemistries	☐	☐	☐	☐		
Cholesterol	☐	☐	☐	☐		
Urinalysis (clean catch)	☐	☐	☐	☐		
Newborn Screening (<28 days)	☐	☐	☐	☐		
Population Specific Testing:						
Test: _____	☐	☐				
Test: _____	☐	☐				

	Negative	Positive	Not Indicated	Not Done	If Not Done, Reason
Pregnancy Test	☐	☐	☐	☐	

PHYSICAL EXAMINATION For all refugees unless otherwise indicated

	Normal	Abnormal	Not Indicated	Not Done	If Not Done/Reason	Abnormal Findings/Preliminary Diagnosis
Nutritional Status:						
Height/Length	☐	☐	☐	☐		
Weight	☐	☐	☐	☐		
Head Circum (< 3 yrs)	☐	☐	☐	☐		
BMI (> 2 yrs.)	☐	☐	☐	☐		
Physical Findings	☐	☐	☐	☐		
Vital Signs:						
Blood Pressure	☐	☐	☐	☐		
Heart Rate	☐	☐	☐	☐		
Respiratory Rate	☐	☐	☐	☐		
Vision	☐	☐	☐	☐		
Hearing	☐	☐	☐	☐		
Oral/Dental	☐	☐	☐	☐		
Skin	☐	☐	☐	☐		
Cardiac Auscultation	☐	☐	☐	☐		
Respiratory	☐	☐	☐	☐		
Lymph Nodes	☐	☐	☐	☐		
Abdomen	☐	☐	☐	☐		
Genital	☐	☐	☐	☐		

FGM/C Assessement (all females): Signs or Symptoms Elicited ☐ Yes ☐ No

If Yes, specify: _____

Mental/Developmental Health Assessment: Signs or Symptoms Elicited ☐ Yes ☐ No

If Yes, specify: _____

Are there any physical or mental conditions limiting employability or school attendance? ☐ Yes ☐ No

If Yes, specify: _____

Multivitamins Given (All children 6-59 months, and children >5 and adults with poor nutrition) ☐ Yes ☐ No

DISEASE SPECIFIC SCREENING See Protocol for testing criteria guidelines

Tuberculosis: TB Skin Test Results: Date PPD Read: ____/____/____ (M M D D Y Y Y Y) _____ mm

– OR –

Date IGRA Result: ____/____/____ (M M D D Y Y Y Y) ☐ Positive ☐ Negative ☐ Indeterminate

Chest X-Ray Date of X-Ray: ____/____/____ (M M D D Y Y Y Y)

☐ Normal ☐ Abnormal ☐ Consistent with Active TB ☐ Not Done/Reason _____

Lead: Child 6 mo. through 16 yrs. ☐ Normal ☐ Abnormal _____ mcg/dl ☐ Not Done/Reason _____

Malaria: Is the patient Sub-Saharan African (SSA) ☐ Yes ☐ No

If SSA: was Pre-Departure Treatment received ☐ Yes (as per individual record and/or CDC treatment schedule) ☐ No

If no pre-departure treatment:

Provide presumptive treatment in lieu of testing ☐ Yes ☐ No ☐ Not Done/Reason _____

OR

Conduct Screening ☐ Positive ☐ Negative ☐ Not Done/Reason _____

DISEASE SPECIFIC SCREENING (continued) See Protocol for testing criteria guidelines

Intestinal Parasites:

Was Pre-departure Treatment received: ☐ Yes (as per individual record and/or CDC treatment schedule) ☐ No

If no pre-departure treatment:

Provide presumptive treatment in lieu of testing:

Soil-transmitted Helminths (STH) (all refugees ≥ 6 months) ☐ Yes ☐ No ☐ Not Done/Reason _____

Strongyloidiasis (all refugees, see Protocol for exceptions) ☐ Yes ☐ No ☐ Not Done/Reason _____

Schistosomiasis (sub-Saharan Africans) ☐ Yes ☐ No ☐ Not Done/Reason _____

OR

Provide Testing:

For STH, conduct stool ova and parasite screening x2: ☐ Positive ☐ Negative ☐ Not Done/Reason _____

If positive, parasites identified: _____

Conduct serologies for:

Strongyloidiasis ☐ Positive ☐ Negative ☐ Not Done/Reason _____

Schistosomiasis (sub-Saharan Africans) ☐ Positive ☐ Negative ☐ Not Done/Reason _____

Sexually Transmitted Infections:

A. Syphilis Testing Documented Overseas ☐ Negative ☐ Positive ☐ Not Documented

If no Syphilis screening- screen per protocol

Syphilis (≥ 15 yrs, or those with risk factors) ☐ Negative ☐ Positive ☐ Not Indicated ☐ Not Done/Reason _____

If positive, Confirmatory Test ☐ Negative ☐ Positive ☐ Not Indicated ☐ Not Done/Reason _____

B. Chlamydia (sexually active females ≤ 25 yrs, or those with risk factors) ☐ Negative ☐ Positive ☐ Not Indicated ☐ Not Done/Reason _____

C. HIV (all refugees, unless opted out) ☐ Tested ☐ Opted out ☐ Not Done/Reason _____

D. Gonorrhea Testing Documented Overseas ☐ Negative ☐ Positive ☐ Not Done/Reason _____

If tested in U.S. ☐ Negative ☐ Positive

Hepatitis:

A. Hepatitis B Testing Documented Overseas ☐ Negative ☐ Positive ☐ Not documented

If no Hepatitis B screening - screen per protocol

All Refugees HBsAg ☐ Negative ☐ Positive ☐ Not Indicated ☐ Not Done/Reason _____

Adults (>18 yrs.) Anti-HBc ☐ Negative ☐ Positive ☐ Not Indicated ☐ Not Done/Reason _____

Adults (>18 yrs.) Anti-HBs ☐ Negative ☐ Positive ☐ Not Indicated ☐ Not Done/Reason _____

B. Hepatitis C

Adults (>18 years and others as per protocol.) Anti-HCV ☐ Negative ☐ Positive ☐ Not Indicated ☐ Not Done/Reason _____

IMMUNIZATIONS Provide initial doses of missing or undocumented age-appropriate vaccines (per ACIP guidelines) given at Health Assessment.

Immunizations	Given at HA	Date Administered	Immunizations	Given at HA	Date Administered
DPT/TD/TDAP	☐ Yes	__/__/__	Pneumococcal	☐ Yes	__/__/__
OPV/IPV	☐ Yes	__/__/__	HPV	☐ Yes	__/__/__
HIB	☐ Yes	__/__/__	Meningococcal	☐ Yes	__/__/__
HBV	☐ Yes	__/__/__	Rotavirus	☐ Yes	__/__/__
Hep A	☐ Yes	__/__/__	Shingles	☐ Yes	__/__/__
MMR	☐ Yes	__/__/__	Other	☐ Yes	__/__/__
Varicella	☐ Yes	__/__/__	Other	☐ Yes	__/__/__
Influenza	☐ Yes	__/__/__	Other	☐ Yes	__/__/__

Dates of Health Assessment: Visit #1: __/__/____ (M M D D Y Y Y Y) Visit #2 __/__/____ (M M D D Y Y Y Y)

Referrals Made: Primary Care Referral ☐ In Network ☐ Out of Network

Referral #1, Type: _____ Referral #1, Reason: _____

Referral #2, Type: _____ Referral #2, Reason: _____

Referral #3, Type: _____ Referral #3, Reason: _____

Health Assessment Provider:

NPI Number _____

Signature: _____

Print Name: _____