U.S. COMMITTEE FOR REFUGEES AND IMMIGRANTS

MISSOURI REFUGEE HEALTH ASSESSMENT FORM

Alien #: ____-____-_____ File # _____

Last Name: _____ First and Middle Name: _____

Date of Birth *(mm/dd/yyyy)*: _____ Gender: ☐ M ☐ F

Arrival Status: ☐ R ☐ A ☐ P ☐ VT ☐ SIV U.S. Arrival Date *(mm/dd/yyyy)*: _____

Country of Origin *(of refugee group)*: _____ City of Residence: _____

County *(of clinic)*: _____ Voluntary Agency: _____

Overseas Classifications: TB Class: ☐ B1 ☐ B2 ☐ History of Overseas Immunizations

Overseas Medical Conditions *(from list)*: _____

☐ I-693 Completed ☐ Secondary Migrant From *(MO county or U.S. state)*: _____

First Screening Date *(mm/dd/yyyy)*: _____ Medical Record# _____

Vaccine-Preventable Disease/Immunization	Evidence of immunity?	Domestic Immunization Date(s) *(mm/dd/yyyy)*				
MMR	☐					
Varicella	☐					
Hepatitis A	☐					
Hepatitis B	☐					
Diphtheria, Tetanus, Pertussis (DTap)						
Tetanus, Diphtheria, Pertussis (Tdap)						
Tetanus, Diphtheria (Td)						
Polio						
Haemophilus influenza type b (Hib)						
Rotavirus						
Meningococcal						
Influenza						
Pneumococcal						
Human Papillomavirus (HPV)						
Zoster						

TB Screening:

1. Tuberculin Skin Test (TST) mm Induration: _____
   ☐ IGRA Test Only *Not Done:* ☐ Past history of positive TST ☐ Given, not read ☐ Declined test ☐ Tested elsewhere ☐ Previous severe reaction
2. IGRA Test: ☐ Positive ☐ Negative ☐ Indeterminate

Hepatitis Screening:

1. Hepatitis B: ☐ Not done, why not? _____
   Anti-HBs: ☐ Negative ☐ Positive HBsAg: ☐ Negative ☐ Positive Anti-HBc: ☐ Negative ☐ Positive
2. Hepatitis C (Optional): ☐ Negative ☐ Positive

Sexually Transmitted Infections:

1. Syphilis *(Age 15 and Above Only)* ☐ Negative ☐ Positive ☐ Not done, why not? _____
2. Chlamydia *(Females Age 15-25 Only)* ☐ Negative ☐ Positive ☐ Not done, why not? _____

Alien #: ____-____-_____ Last Name: _____

3. HIV ☐ Negative ☐ Positive ☐ Not done, why not? _____
4. Other, specify: _____ ☐ Negative ☐ Positive

Intestinal Parasite Screening: *Check all that apply:*

Ova & Parasite Tests:

☐ Not screened for parasites; why not? _____
☐ Screened, no parasites found
☐ Screened, non-pathogenic parasites found
☐ Screened, pathogenic parasites found (check all that apply)
☐ Screened, BOTH pathogenic and non-pathogenic parasites found (check all that apply)

☐ Ascaris	☐ Hookworm
☐ Clonorchis	☐ Schistosoma
☐ Dientamoeba	☐ Strongyloides
☐ Entamoeba hystolica	☐ Trichuris
☐ Giardia	☐ Other: _____

CBC with differential done? ☐ Yes ☐ No If not done, why not? _____
If yes, was Eosinophilia present? ☐ Yes ☐ No If yes, was further evaluation done? ☐ Yes ☐ No

Serology Tests:
Schistosoma *(Sub-Saharan African Origin Only)* ☐ Negative ☐ Positive ☐ Not done, why not? _____
Strongyloides ☐ Negative ☐ Positive ☐ Not done, why not? _____

Currently Pregnant: ☐ Yes

Malaria Screening *(Sub-Saharan African Origin Only)*:
☐ Not screened for malaria; why not? _____
☐ Screened, no malaria species found in blood smears
☐ Screened, malaria species found *(Please specify)*: _____

Hemoglobin (g/dL):	Hematocrit (%):	Lead Screened ☐ Yes ☐ No (6 mo-16yr) BLL (µg /dl):	Height (in):	Weight (lbs):	BP-Systolic (mm Hg):	BP-Diastolic (mm Hg):

If any of the boxes are left blank (besides lead), please check the following box and provide a reason:
☐ Not done, why not? _____

1. **Cholesterol** ☐ Not elevated ☐ Elevated ☐ Not done, why not? _____
2. **UA** ☐ Normal ☐ Abnormal ☐ Not on protocol ☐ Not done, why not? _____
3. **B/CMP** ☐ Done ☐ Not done, why not? _____

Referrals *(Check all that apply)*

☐ Primary Care	☐ Dental	☐ Vision	☐ Mental Health
☐ Hearing	☐ Family Planning	☐ WIC	☐ Dermatology
☐ TB Program	☐ GI	☐ OB/GYN	☐ Pediatrics
☐ Social Work	☐ Endocrinology	☐ Urology	☐ Ear, Nose & Throat (ENT)
☐ Cardiology	☐ Neurology	☐ Hematology	☐ Ortho
☐ Pulmonology	☐ Other Referral: _____	☐ Disability *(Type)*: _____	

☐ Emergency/Urgent Care (*Reason*): _____

Interpreter needed: ☐ Yes ☐ No If Yes, language needed: _____

Date screening completed *(mm/dd/yyyy)*: _____ **Date submitted** (*mm/dd/yyyy*): _____

Outcome *(if applicable)*
☐ Moved out of state: _____ ☐ Moved out of county: _____
☐ Unable to locate ☐ Never arrived ☐ Missed appointment ☐ Died before screening ☐ Vaccines only
☐ Moved to unknown destination ☐ Screened elsewhere- no results ☐ Refused screening ☐ Hospitalized

Send completed form via encryped email to:
Taysir Al Janabi - taljanabi@uscridc.org
(703) 310 - 1130 ext. 3069