

WISCONSIN INITIAL REFUGEE HEALTH ASSESSMENT

Client information is confidential under Wisconsin Statute 146.82(1)
Please read instructions before completing this form.

General Information (Review overseas medical documentation)

Admission Status: Asylee Amerasian Cuban/Haitian Victim of Trafficking Refugee Immigrant

Name - First, Middle, Last (include name suffix i.e. Jr., Sr. etc.)

Alien or Visa Registration No.	Race	Date of Birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
U.S. Arrival Date	Country of Origin	Refugee Camp/Port of Entry	
Class B TB status: Class: <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3 <input type="checkbox"/> No <input type="checkbox"/> Yes (requires follow-up soon after arrival)		Class B, Other Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes (requires follow-up soon after arrival)	
Family File number		Resettlement agency ("VOLAG") and contact person/telephone no.	

How will clinic be reimbursed for this screening?

Medical Assistance Health Screening Contract Other _____

Date of First Clinic Visit for Screening:

Interpreter Needed? Yes No
If yes, which language? _____
Literate in own language? Yes No

Vital Signs

Height (in.):	Weight (lbs):	Head Circum (inches) infants and children:	BMI:
BP:	Pulse:	Resp:	Temp:

Significant information from physical exam:

Wheel chair/ mobility device Dialysis Oxygen Other: _____

Vision and Hearing Screening (check all that apply)

Vision Screening: Not done Wears glasses/contacts

OD 20/ _____ OS 20/ _____

Hearing Screening:

Normal Abnormal Uses aids Not done

Oral Screening (check all that apply)

Urgent Referral

- Oral Screening not done
- Cavities/caries present and pain present
- Pain present in teeth and/or jaw with or without biting/chewing
- Open sores present in mouth or gums

Early Referral

- Cavities/caries present but no pain
- Periodontal disease signs present (redness, swelling and/or sores on gums, and/or hard build-up on teeth)

Preventive Referral

- Apparent fillings present
- Apparent dental sealants
- No apparent problems or dental disease

Comments: _____

Past Medical History

Current Medications

None Yes (list/attach) _____

Medication Allergies

None Yes (list/attach) _____

Herbal/Traditional treatments

None 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	Skin:	<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 (type, amt): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Genitourinary/Renal:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnant: <input type="checkbox"/> Yes	EDD: _____	<input type="checkbox"/> No	Drug use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LMP: _____	G: _____	P: _____	AB: _____	Other (ie, betel nut use, khat) _____	

Family/Social History

Diabetes: Yes No Hypertension: _____ Yes No

Sickle Cell Anemia: Yes No Other: _____ Yes No

Travel History (country of birth, route to U.S.): _____ Occupational History (i.e., environmental, chemical exposures): _____

Vaccine – Preventable Disease/Immunization Overseas immunizations done

Check if there is evidence of immunity; no immunization needed	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Measles	<input type="checkbox"/>					
Mumps	<input type="checkbox"/>					
Rubella	<input type="checkbox"/>					
Varicella (VZV)	<input type="checkbox"/>					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)						
Diphtheria Tetanus (Td)/Tdap*						
Polio (IPV)						
Hepatitis B (Hep B)	<input type="checkbox"/>					
<i>Haemophilus influenzae</i> type b (Hib)						
Hepatitis A (Hep A)	<input type="checkbox"/>					
Influenza						
Pneumococcal (PCV3**, PPSV23)						
Meningococcal conjugate (MCV4)						
Rotavirus						
Human Papilloma Virus (HPV)						
Zoster (shingles)						

*Tetanus, diphtheria and acellular pertussis (Tdap) vaccine is recommended to satisfy the Td booster requirement. Tdap vaccine can be administered to persons 7 years of age and older.

**Children less than 6 years of age should receive the PCV13 vaccine. Adults aged 65 and older should receive one dose of PPSV23.

Statement of Rights

Information collected on this form is for the Wisconsin Division of Public Health (DPH), by authority of Section 412(7) of the Immigration and Nationality Act as amended by the Refugee Act of 1980. This information is used to obtain a health evaluation and/or treatment for the patient. Wisconsin State Statute authorizes collection of this information under s. 250.04. In order to provide services, it may be necessary to release information from the patient's record to individuals or agencies that are involved in the care of the individual. Such individuals and agencies usually include family physicians and/or dentists, medical and dental specialists, public health agencies, hospitals, schools, and day care centers. All public health agencies, health institutions, or providers to whom the refugee has appeared for treatment or services shall be entitled to the information included on this form.

Review of Systems (*NL, normal; *A, abnormal)

	*NL	*A	Description		*NL	*A	Description
Constitutional Symptoms	<input type="checkbox"/>	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>		Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>		Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>		Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>		Hematologic, Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>		Allergic, Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	
Gynecologic	<input type="checkbox"/>	<input type="checkbox"/>					

Physical Exam (*NL, normal; *A, abnormal) [Description ex: *Pallor, Hepatosplenomegaly, Lymphadenopathy, Nutritional status*]

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

Preventive Health Interventions

Tuberculosis Screening

Risk factors for TB infection: Known contact with another person with TB disease, born or lived or visited in country where TB is common.

Risk factors for TB disease: Immunosuppression, diabetes, advanced or young age, <90% ideal body weight, renal disease, smoker, cancer.

Signs/ Symptoms (check all that apply):

- fever weight loss night sweats
- pulmonary complaints
- diarrhea/abdominal complaints
- pruritis/skin lesions/rash, malaise, hemoptysis

Interferon-Gamma Release Assays (IGRAs)

NOTE: TST is preferred for testing children aged <5 years old.

Blood test used: T-spot QFT Not done

Negative Positive Indeterminate Invalid

Quantitative results:
 Nil
 TB mitogen _____
 Mitogen

Tuberculin Skin Test

Not done
 Date placed: _____
 Date read: _____
 Induration: _____ mm

Chest x-ray: (taken in U.S.)

Normal
 TB - non-cavitary
 TB - cavitary
 Stable, no change to overseas film
 Not done; Reason: _____

Sputum: Yes No **If yes, give date (mm/dd/yy) and result:**

Date - result: ___/___/___ - _____
Date - result: ___/___/___ - _____
Date - result: ___/___/___ - _____

TB Therapy: (if indicated)

- Treatment of suspected or confirmed TB disease; date began _____
- Treatment of TB infection (TBI) prescribed; date started _____
- No TBI treatment; Reason: _____
- Documented treatment overseas for active TB disease completed
- Pregnancy Refused Other _____

Hepatitis B Screening

Anti-HBs (check only one) Negative Positive; **Note:** if positive patient is immune Results pending
HbsAg (check only one) Negative Positive Results pending

Note: If positive, patient is infected with HBV and infectious to contacts, and it is important to screen all household contacts.

If positive HbsAg, were all household contacts screened? Yes No

If Yes, were all susceptibles started on vaccine? Yes No If No, why not? _____

Referred for follow-up? Yes No

Anti-HBc (check only one) Negative Positive Results pending Not done

IgM anti-HBc (check only one) Negative Positive Results pending Not done

Note: If positive, patient has acute HBV infection. If positive IgM anti-HBc was patient referred for follow-up? Yes No

Urinalysis (Screen for indicators of chronic conditions for any patient old enough to produce a clean catch specimen)

Glycosuria: Positive Negative Proteinuria: Positive Negative Hematuria: Positive Negative

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

Screened? Yes _____ (date) Not Done Results: Negative Positive

HIV Screening 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 (no history of high-risk exposures such as blood product transfusions, early sexual activity, or sexual abuse).

Negative Positive; referred to Infectious Disease Specialist? Yes No Testing not done, why? _____

Syphilis Screening Routine testing for syphilis for refugees >15 years of age.

Screening tests (VDRL/RPR) Negative Positive Not done, why? _____

Positive; if treated Tx: _____ Not treated, why? _____

Confirmation test (FTA/TPPA) Negative Positive Not done, why? _____

Chlamydia/ Gonorrhea Screening (Urine Specimen) Chlamydia testing for women ≤25 years of age or older with risk factors.

Chlamydia Negative Positive; treated? Yes No Results pending Not done, why? _____

Gonorrhea Negative Positive; treated? Yes No Results pending Not done, why? _____

Other Sexually Transmitted Diseases

Specify: _____ Negative Positive; treated? Yes No Results pending

Not done, why? _____

Intestinal Parasite Screening

Pre-departure presumptive treatment? Yes No Unknown If known, specify treatment: _____

Was screening for parasites done?

Screened, results pending Screened, no parasites found Screened, parasites found: (check all that apply below)

Note: Stool tests for Strongyloides can be difficult to validate. Presumptive treatment with ivermectin is appropriate if signs and symptoms warrant.

<input type="checkbox"/> Ascaris	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hookworm	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Blastocystis (non-pathogenic)	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Schistosoma	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Clonorchis	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Strongyloides	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cryptosporidium	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trichinella	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cyclospora	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trichuris	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Entamoeba histolytica	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other, specify: _____	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Giardia	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Not screened for parasites; why? _____

Parasites not treated; why? _____

Malaria Screening

Pre-Departure presumptive treatment? Yes No Unknown
 All sub-Saharan Africans are presumptively treated before departure.
www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html

History of malaria exposure: Yes No
 Evidence of infection or symptoms of malaria: Yes No
 Screened: Yes No Screened, results pending

If malaria species found:

ovale falciparum vivax malariae
 Not identified

Treated? Yes No

Referred for treatment? Yes No

If referred for treatment, specify physician/ clinic:

Lead Screening (<17 years old)

Screened? Not done Yes
 Negative BLL _____ (elevated BLL $\geq 10\mu\text{g/dL}$)
 Referred for treatment? Yes No

NOTE: Recheck all children aged 6 months- 6 years within 3-6 months of arrival, regardless of results of initial lead screen.

Mental Status

Does the overseas medical record indicate a diagnosis of mental illness?: Yes No

If yes, treated or referral Yes No

Are there physical signs of maltreatment (scar, deformities – torture)? Yes No

Did the refugee become unusually anxious or agitated during the physical exam? Yes No

Questions that can be asked at different points in the screen:

1. Trouble sleeping? Yes No Have you experienced any nightmares? Yes No
2. Any change in your energy level? Yes No
3. Unexplained somatic symptoms (headaches, stomach aches, or back pain)? Yes No
4. Have you noticed any change in your appetite (increase or decrease? with weight change?) Yes No

If behavior or answers to probes above indicate, ask,

Are you willing or interested in speaking with a mental professional? Yes No

Do you have thoughts of harming yourself or hurting others? Yes No

5. If mental health screen is positive, identify main caregiver, inquire about **caregiver stress**.

How is caregiver managing stress of this role? _____

Blood Work (Please Complete This Section For All Refugees; Please Attach Or Fax All Results)

CBC with differential done? Yes No

Hemoglobin results: _____ Not done Hematocrit results: _____ Not done

Was Eosinophilia present? Yes No If yes, was further evaluation done? Yes No Results pending

Vitamin B12 (pg/ml) Results: _____ Not done

Blood Glucose (mg/dl) Results: _____ Not done ALT: _____ AST: _____ Other: _____

Additional Labs and Screening (Based on risk factors and/or signs and symptoms identified during the exam)

Population specific CMP; lipid panel Cancer screening Metabolic screening in newborns

Vitamin D deficiency Sickle Cell Anemia Hepatitis A Hepatitis C (all sub-Saharan arrivals; others as needed)

Referrals (Check all that apply)

Primary Care Provider Vision Dermatology Communicable Disease, ID Mental Health referral for:
 referral for: _____

Dental Hearing Public Health/WIC Family Planning Medical/Other: _____

Vitamins recommended? Multivitamin Prenatal Vitamin D Other: _____

Medical Home:

Primary Provider:

Health System:

Screening Provider (If more than one agency is involved in health assessment, include information on both agencies.)

Agency One:

Agency Two:

Contact Person:

Contact Person:

Address:

Address:

Telephone Number:
()

Telephone Number:
()

Fax:
()

Fax:
()

Submitter/Contact:

Contact Telephone Number:
()

Fax completed form to the Wisconsin Department of Health Services, Division of Public Health, Bureau of Communicable Diseases and Emergency Response, Refugee Health Coordinator at **(608) 266-0049** or mail to:

Wisconsin Division of Public Health
Attn: Refugee Health Coordinator
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