Georgia Department of Public Health

REFUGEE DOMESTIC HEALTH ASSESSMENT FORM/INVOICE

To Be Completed By Health Providers

COUNTY:	ALIEN #:	DATE OF HEALTH ASSESSMENT: MM DD YYYY
PATIENT'S NAME:	SEX: ☐ M ☐ F	DATE OF BIRTH: MM DD YYYY
STREET ADDRESS: / CITY: / ZIP:	PORT OF ENTRY:	HOME TELEPHONE:
I-94 STATUS: ☐ Refugee ☐ AM Immigrant ☐ Asylee ☐ Cuban/Haitian Parolee ☐ Victim of Human Trafficking ☐ Special Immigrant Visa	COUNTRY OF BIRTH:	SPONSOR (Choose One): ☐ NAP ☐ LSG ☐ WR ☐ No VOLAG ☐ IRC ☐ CSS ☐ Tapestri
	LANGUAGE INTERPRETATION NEEDED ? ☐ YES ☐ NO INTERPRETATION PROVIDED BY: ☐ COUNTY ☐ STATE ☐ LANGUAGE LINE	DATE OF ARRIVAL: MM DD YYYY OVERSEAS TB CLASS A , B1, OR B2 STATUS? (REVIEW OVERSEAS DOCUMENTS) ☐ NONE ☐ YES, SPECIFY _____

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. POLIO: NUMBER OF OVERSEAS DOSES ON OVERSEAS DOCUMENT (1, 2 ,3, NONE).
4. IF VACCINATED IN U.S., NOTE FULL DATE (MM/DD/YYYY).

	IS PERSON IMMUNE ?	MM/DD/YYYY	FEE
MEASLES, MUMPS & RUBELLA (MMR)	Y N I		☐ $63
TETANUS/DIPHTHERIA (TD)	Y N I		☐ $30
DIPTHERIA/TETANUS/PERTUSSIS (Tdap)	Y N I		☐ $43
HEPATITIS A & B (Twinrix)	Y N I		☐ $93
PNEUMOCOCCAL	Y N I		☐ $79
VARICELLA (Chickenpox)	Y N I		☐ $108
POLIO	1 2 3 NONE		

	MM/DD/YYYY
HUMAN PAPILLOMA VIRUS	
ZOSTER (SHINGLES)	
HAEMOPHILUS INFLUENZA TYPE B	
INFLUENZA (SEASONAL)	
MENINGOCOCCAL CONJUGATE	

IMMUNIZATION CATCH-UP SCHEDUL BEGUN? ☐ YES ☐ NO

Note: Reimbursement is for <u>one</u> dosage only.

TUBERCULOSIS SCREENING & DIAGNOSIS -- REPORT TESTS DONE IN U.S. *ONLY*

☐ PPD $9 ☐ IGRA/QFT $80 ☐ CXR $24 $ _____

DATE OF TEST

TUBERCULIN SKIN TEST (TST) MM DD YYYY

MM INDURATION _____

TEST RESULTS: TST

☐ POSITIVE ☐ NEGATIVE ☐ PENDING

INTERFERON-GAMMA RELEASE ASSAYS (IGRA) MM DD YYYY

IGRA TYPE: ☐ QFT ☐ T-SPOT

TEST RESULTS: IGRA

☐ POSITIVE ☐ NEGATIVE ☐ PENDING

CHEST X-RAY: ** REPORT *ONLY* X-RAY DONE IN U.S. MM DD YYYY

TEST RESULTS: CXR

☐ NORMAL ☐ ABNORMAL ☐ PENDING

☐ REFERRED FOR CHEST X-RAY

TUBERCULOSIS DIAGNOSIS (MUST CHECK ONE)

☐ NO TB INFECTION OR DISEASE

☐ LATENT TB INFECTION (LTBI)

REFERRED FOR FOLLOW-UP? ☐ YES ☐ NO

APPOINTMENT DATE: MM DD YYYY

LTBI TREATMENT STARTED?

☐ YES ☐ NO ☐ UNKNOWN

☐ ACTIVE DISEASE – REFERRED FOR FOLLOW-UP

APPOINTMENT DATE: MM DD YYYY

☐ PENDING, FOLLOW-UP NEEDED

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

☐ HEP B $43 ☐ HEP C $20 $ _____

HBV (Hep B)

HBsAg ☐ NEGATIVE ☐ POSITIVE [IF POSITIVE, PATIENT IS INFECTIOUS] ☐ INDETERMINATE ☐ RESULTS PENDING

HBcAB ☐ NEGATIVE ☐ POSITIVE [IF POSITIVE, PATIENT IS IMMUNE] ☐ INDETERMINATE ☐ RESULTS PENDING

Anti HBs ☐ NEGATIVE ☐ POSITIVE ☐ INDETERMINATE ☐ RESULTS PENDING

REFERRED FOR FOLLOW-UP? ☐ YES ☐ NO

APPOINTMENT DATE: MM DD YYYY

HCV (Hep C) [ONLY FOR REFUGEES IN HIGH RISK GROUPS. SEE CDC GUIDELINES]. ☐ NEGATIVE ☐ POSITIVE ☐ INDETERMINATE ☐ RESULT SPENDING

HIV/ SEXUALLY TRANSMITTED INFECTIONS/ DISEASES

☐ HIV TEST $20 ☐ SYPHILIS $6.23 ☐ GC $17 $ _____

HIV (TEST ALL PERSONS 13-64 YEARS OF AGE: NO OVERSEAS HIV TESTS ARE GIVEN AS OF 2010. (SEE CDC GUIDELINES FOR SCREENING CHILDREN)

TESTED? ☐ YES ☐ NO IF, APPLICABLE 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)

VDRL/RPR ☐ NEGATIVE ☐ POSITIVE ☐ PENDING ☐ NOT DONE

IF POSITIVE, CONFIRMATORY TEST (TPPA, FTA, ABS) DONE? ☐ YES ☐ NO

TREATED? ☐ YES ☐ NO ☐ REFERRED

OR

EIA: ☐ NEGATIVE ☐ POSITIVE ☐ PENDING ☐ NOT DONE

IF EIA POSITIVE , WERE VDRL/RPR AND/ OR OTHER CONFIRMATORY TEST(S) DONE? ☐ YES ☐ NO

TREATED? ☐ YES ☐ NO ☐ REFERRED

CHLAMYDIA (Women up to 26 years old or older with risk factors.) ☐ NEGATIVE ☐ POSITIVE ☐ PENDING ☐ NOT DONE

GONORRHEA (FOr specific groups – see CDC guidelines) ☐ NEGATIVE ☐ POSITIVE ☐ PENDING ☐ NOT DONE

INTESTINAL PARASITES (NOTE: CDC PROTOCOLS ARE BASED ON OVERSEAS TREATMENT)

☐ INTESTINAL PARASITES /STOOL $15 $ _____

U.S. PRESUMPTIVE TREATMENT GIVEN? SCHISTOSOMA ☐ YES ☐ NO STRONGYLOIDES ☐ YES ☐ NO REFERRED FOR FOLLOW-UP? ☐ YES ☐ NO

TESTING FOR PARASITES

STOOL SPECIMEN (OVA & PARASITES) ☐ YES ☐ NO ☐ RESULTS PENDING ☐ NO PARASITES FOUND ☐ PARASITES FOUND _____

SEROLOGY TEST ☐ YES ☐ NO ☐ RESULTS PENDING

SCHISTOSOMA ☐ NEGATIVE ☐ POSITIVE; TREATED? ☐ YES ☐ NO ☐ TEST RESULT INDETERMINATE

STRONGYLOIDES ☐ NEGATIVE ☐ POSITIVE; TREATED? ☐ YES ☐ NO ☐ TEST RESULT INDETERMINATE

LABORATORY TESTS

☐ URINALYSIS $4 ☐ CHOLESTEROL $6 ☐ HDL $11 ☐ CBC w/Differentials $11 $ _____

URINALYSIS DONE? ☐ YES ☐ NO **SERUM CHEMISTRY DONE?** ☐ YES ☐ NO **CHOLESTEROL DONE?** ☐ YES ☐ NO

CBC 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)

PHYSICAL ASSESSMENT, SCREENING CONDUCTED

$ _____

☐ Age 21-39 $128 ☐ Age 40-64 $149 ☐ Age 65/older $161

HYPERTENSION	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
DIABETES	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
ANEMIA	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
MALNUTRITION	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
HEARING	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
VISUAL ACUITY	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
DENTAL	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
MALARIA	☐ YES	☐ NO	☐ PENDING	☐ REFERRED

PREGNANCY $9 ☐ YES ☐ NO ☐ PENDING ☐ REFERRED $ _____

LEAD (<16 years) ☐ POS ☐ NEG LEAD LEVEL_____ ☐ REFERRED

MENTAL HEALTH SCREENING

WAS A U.S. MENTAL HEALTH SCREENING PERFORMED? ☐ YES ☐ NO

REFERRED FOR FOLLOW UP? ☐ YES ☐ NO

APPOINTMENT DATE: ___/___/___ (MM DD YYYY)

OTHER REFERRALS (CHECK ALL THAT APPLY):

☐ PRIMARY CARE ☐ INFECTIOUS DISEASE ☐ HIV/STI/STD

☐ WOMEN'S HEALTH ☐ NEWBORN SCREENING ☐ PRENATAL CARE

☐ WIC ☐ PARASITOLOGY

☐ PAIN ☐ HEALTH EDUCATION

OTHER _____

TOTAL REIMBURSEMENT CLAIMED $ _____

AUTHORIZING SIGNATURE (PHYSICIAN OR NURSE):

TITLE:

FACILITY NAME:	TELEPHONE:	FAX:	DATE OF THIS REPORT: (MM DD YYYY)

PLEASE SEND COMPLETED ENCRYPTED FORM TO: Catrice.Ricks@dph.ga.gov and Monica.Vargas@dph.ga.gov