Initial Screening Date (mm/dd/yyyy): _____
Final Screening Date (mm/dd/yyyy): _____

Refugee Health Assessment Summary

DEMOGRAPHICS

Name (As indicated on Assurance Form)		Gender ☐ Male ☐ Female		Alien #
DOB (mm/dd/yyyy)	Address	Sponsor Name & Phone #		Case Manager Name & Phone #
Health Screening Agency	Resettlement/Volunteer Agency	Date of Arrival in the U.S.	Country of Birth	Screening Physician/Nurse

ASSESSMENT FINDINGS

Diagnosis: ☐ Refugee Health Assessment completed ☐ Abnormal exam or medical history findings (see Notes below) ☐Pregnancy
☐ Stool/Serology tested positive for ova or parasites ☐ Latent Tuberculosis Treatment ☐ Tuberculosis ☐Other _____

Labs ordered: ☐ Stool for O&P ☐ Sputum ☐ Chest X-Ray ☐ Immunization titers ☐ Complete Blood Count (CBC) with differential
☐ Blood Lead Level ☐ Liver Function Test (LFT) ☐ HIV Test ☐ Hepatitis B Antigen ☐ Syphilis (RPR)
☐ Gonorrhea/Chlamydia

Lab Results (see Health Assessment Form): Health Assessment Form Attached? ☐ Yes ☐ No

Immunizations administered: ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ DTaP/Tdap/Td ☐ Influenza ☐ Twinrix (Hep A & B) ☐ Other _____

Immunization Titers—Immune to:
☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Hepatitis B ☐ Hepatitis C

REFERRALS

You have been referred to: ☐ Primary Care Provider for further medical care ☐ Dentist ☐ WIC/Nutritionist ☐ Optometrist ☐OB/GYN
☐ LHD TB Program for further evaluation/start medication (LHD/other referral center: _____)
☐ Specialist for _____
☐ Other _____
☐ None

You will need a follow-up appointment within _____ (specify timeframe) **for** _____ (specify purpose).

MEDICATIONS

Medications prescribed? ☐ Yes ☐ No

Please list names of medications and reason prescribed:

_____

_____

_____

NEXT STEPS

☐ Call the number on your insurance card to schedule an appointment with your doctor.
☐ Your next appointment is on _____(date/time) for _____ (purpose).
☐ Call _____ if you have any questions or concerns about your refugee health assessment.
☐ Take medication as directed.
☐ Recommend stool parasite follow-up per CDC guidelines: http://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-domestic.pdf.
☐ Give a copy of this form to your doctor or nurse.

NOTES

_____

_____

_____

_____ Name of person completing the form

_____ Signature of person completing the form

_____ Date