Georgia Department of Public Health
REFUGEE DOMESTIC HEALTH ASSESSMENT FORM/INVOICE
To Be Completed By Health Providers

SECTION 1

1) Alien Number ☐☐☐ **2) Date Of Arrival** ☐☐☐ **3) Port of Entry** _____

4) Last Name: _____ **5) Sex** ☐ **6) DOB** ☐☐☐

7) Country of Origin:_____ **8) County**:_____

9) Sponsor 1:_____ **10) Sponsor 2**:_____
(Volag) (Volag)

Phone ☐☐☐ City:_____ Phone ☐☐☐

11) I-94 Status: ☐ Refugee ☐ AM Immigrant ☐ Asylee ☐ Cuban/Haitian Parolee ☐ Victim of Human Trafficking

12) Previous Resettlement: ☐ Yes ☐ No From:_____

13) Class A or B: ☐ A ☐ B For:_____

SECTION 2

14) Initial Health Assessment Date:_____

15) Where Screened? ☐ **CHD** ☐ **CHC** ☐ **FQHC**

Interpeter Needed? ☐ **Yes** **Interpreter is Employed with:** ☐ **County** ☐ **State** ☐ **Language Line**

☐ **No Interpreter Needed.** ***NOTE*** **: Family and friends *not* recommended as interpreters.**

How will your clinic be reimburse for this screening? ☐ **RMA** ☐ **Medicaid** ***(Children age 0-20 bill to Medicaid)***

Condition	Services Or Examination	Abnormal Result	Normal Result	Not Tested/ Declined	Follow-Up Recommended	Fee Schedule	Reimbursement Claimed
16) Tuberculosis	QFT / IGRA	☐	☐	☐	☐	**$80.00**	**$**
	Mantoux PPD	☐ _____mm	☐	☐	☐	**$9.00**	
	Chest X-Ray	☐	☐	☐	☐	**$24.00**	
	Bacteriology	☐	☐	☐	☐		
17) Hepatitis B	HBsAG	☐	☐	☐	☐	**$43.00**	**$**
	HBcAB	☐	☐	☐	☐		
	Anti HBs	☐	☐	☐	☐		
18) Stool	Ova	☐	☐	☐	☐	**$15.00**	**$**
	Parasites (check all that apply):						
	Ascaris	☐	☐	☐	☐		
	Clonorchis	☐	☐	☐	☐		
	Entamoeba histolytica	☐	☐	☐	☐		
	Giardia	☐	☐	☐	☐		
	Hookworm	☐	☐	☐	☐		
	Paragonimus	☐	☐	☐	☐		
	Schistosoma	☐	☐	☐	☐		
	Strongyloides	☐	☐	☐	☐		
	Tapeworm	☐	☐	☐	☐		
	Trichuris	☐	☐	☐	☐		
	Other (specify): _____	☐	☐	☐	☐		
19) Sexually Transmitted Diseases	GC	☐	☐	☐	☐	**$17.00**	**$**
	Syphilis	☐	☐	☐	☐	**$6.23**	

Condition	Services Or Examination	Abnormal Result	Normal Result	Not Tested/ Declined	Follow-Up Recommended	Fee Schedule	Reimbursement Claimed
20) Physical Assessment							$
Hypertension	Blood Pressure	☐	☐	☐	☐	**Age 21-39 $128**	
Diabetes	Blood Sugar Test	☐	☐	☐	☐	**Age 40-64 $149**	
Anemia	Hct/Hgb	☐	☐	☐	☐	**Age 65/older $161**	
Malnutrition	Observation	☐	☐	☐	☐		
Hearing	Whisper Test	☐	☐	☐	☐		
Visual Acuity	Eye Chart	☐	☐	☐	☐		
Dental	Oral Exam	☐	☐	☐	☐		
Vital Signs	Height:	_____ft. _____ in.					
	Weight:	_____ lbs.					
	Pulse:	_____					
	Blood Pressure:	_____					
	Head Circum:	_____ in.					
	BMI:	_____					
	Respirations:	_____					
	Temperature:	_____ F°					
	Vision Screening:	OD_____/20 OS_____/20					
	Hearing Screen:	☐ Abnormal ☐ Normal					
21) Pregnancy	Pregnancy Test	**POSITIVE** ☐	**NEGATIVE** ☐	**NOT TESTED** ☐	**FOLLOW-UP RECOMMENDED** ☐	**$9.00**	$
22) Immunizations (Age-Appropriate)		**ADMINISTERED**		**NOT NEEDED**	**FOLLOW-UP RECOMMENDED**	**$8.00 Admin Fee for each vaccination highlighted with an (*).**	$
	Td/Tdap *	☐		☐	☐		
	DTAP	☐		☐	☐		
	MMR *	☐		☐	☐		
	Polio	☐		☐	☐		
	Hib	☐		☐	☐		
	Hepatitis A *	☐		☐	☐		
	Hepatitis B *	☐		☐	☐		
	Varicella *	☐		☐	☐		
	Pneumonia *	☐		☐	☐		
23) Lead (<16 years)	Lead Level:_____	☐ POS	☐ NEG		☐		
24) HIV	Tested	☐ Yes ☐ No	**Do Not Include HIV Test Results On This Form**		☐	**$20.00**	$

Additional Labs and Screening: $

☐ Population specific Test for Vitamin B12 Bhutanese with clinical manisfestations suggestive of deficiency. **$3.00 (1 month supply)**

☐ Vitamin D deficiency. **$42.00**

☐ Sickle Cell Anemia **$8.00**

☐ Infant metabolic screening in newborns, according to state guidelines.

☐ In clinic settings allowing for followup in primary care consider: complete metabolic panel; lipid panel if appropriate, cancer screening.

Referrals (check all that apply):

☐ Primary Care ☐ Dental ☐ Vision ☐ Children with Special Health Care Needs

☐ Emergency/Urgent ☐ WIC ☐ Mental Health ☐ Other_____

Vitamins recommended:

☐ Multivitamin ☐ Population Specific:

☐ Vitamin D ☐ Bhutanese, B12

☐ Prenatal ☐ Other_____

Total Reimbursement Claimed

$

_____

Authorizing Signaure **Title** **Date**