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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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Office of Public Health Preparedness and Response

DATE: March 22, 2023 OPHPR-2023-005

TO: Local Health Directors

FROM: Maryanne Pappas, APRN
Nurse Consultant

RE: Migrant Health Screening Form

Attached is a nursing health form that can be utilized for assessing incoming refugees in your jurisdiction. It is in a fillable PDF format. This form is a modified version of the Region 1 assessment form.

Please feel free to use parts or all of it as you see fit for your populations and circumstances. We hope you find the form helpful and useful.

Thank you

att: Migrant Health Screening Form

cc: F. Provenzano, OPHPR
W. Gerrish, OPHPR

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Migrant Health Screening Form

Clear Form

Person Completing Form: _____

Screening Date: _____

Location of Screening (City/Health Department): _____

Demographics:

Name (Last, First, Middle)			Gender
DOB (mm/dd/yyyy)	Age	Country of Birth	Nationality
Ethnicity (Hispanic or Latino) ☐ Yes ☐ No ☐ Unknown	Race (select one or more, if multicultural, check all that apply) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown		

IMMIGRATION STATUS

☐ Refugee ☐ Asylee ☐ Cuban/Haitian ☐ Parolee ☐ Amerasian ☐ Victim of Trafficking ☐ Special Immigration Visa ☐ Migrant

SCREENING INFORMATION

Temperature:	**Pulse:**	**Respirations:**
Blood Pressure:	**Height:**	**Weight:**
Allergies to medication/food/environmental/other	**Medications** **Do you have your medications with you?** **Yes ☐ No ☐**	**Current Medications List**:
Do you have any medical problems (past or present)	**List Medical Problems:**	
Do you have any weapons with you?	☐ **Yes** ☐ **No** **If Yes, What weapon and how was it secured?**	

General Health Status

-Communication Assessment:

What language do you speak?
Interpreter Provided? ☐ Yes ☐ No If yes, Name or INT Number:
If No, patient speaks: ☐ English Fluently ☐ Provider fluent in patients native language ☐ No interpreter available
Do you have any difficulty with: ☐ Hearing ☐ Speech ☐ Vision If yes, what accommodations do you need to help you read, communicate, or navigate the facility?

-Disability Screening:

Do you have any difficulty with walking, standing, or climbing stairs? ☐Yes ☐No If Yes, explain:
Do you have any difficulty reading or writing? ☐Yes ☐No If yes, explain:

-Medical Screening:

How do you feel today?			
Are you currently having any pain? ☐Yes ☐No *If yes, complete pain assessment below:*			
Character of pain:	Location	Duration	Intensity: (0-10 pain scale)
What relieves pain? What makes it worse?			
Have you hospitalized for , surgery, infectious or communicable disease, or other reason ? ☐Yes ☐No If yes, explain:			
Do you now or have you ever had Tuberculosis (TB)? ☐Yes ☐No Have you been tested for TB?			
In the past 2 months, have you experienced any of the following signs or symptoms for more than 2 weeks: Cough? ☐Yes ☐No Coughing up blood? ☐Yes ☐No Chest pain? ☐Yes ☐No Loss of appetite? ☐Yes ☐No Fever, chills, or night sweats for no known reason? ☐Yes ☐No Unexplained weight loss? ☐Yes ☐No			
Symptom screening with positive responses(s) is concerning for active TB: ☐Yes ☐No If yes, explain:			
Have you had any recent sudden changes with your vision or hearing? ☐Yes ☐No If yes, explain:			
Do you have any specific dietary needs? ☐Yes ☐No If yes, explain:			
Have you been vaccinated for COVID-19? ☐Yes ☐No			
Have You had a recent Flu shot? ☐Yes ☐No If so, When?			
Have You been tested for TB? ☐Yes ☐No If so, When?			

-Females Only

Are you pregnant? ☐Yes ☐No ☐Not Applicable If yes, date of last menstrual period:
Are you currently breast feeding? ☐Yes ☐No If yes, When was the last day you breastfed?
Have you had unprotected sexual intercourse in the past 5 days? ☐Yes ☐ No If yes, would you like to speak to a medical provider about emergency contraception to prevent a possible pregnancy? ☐Yes ☐No If yes, contact a medical provider immediately for guidance.

-Oral Screening

Are you having any significant dental problems? ☐ Yes ☐No If yes, explain:
Do you have dentures, partials, braces, etc? ☐Yes ☐No If yes, do you have these items with you?

Mental Health Screening

-General

Have you ever been diagnosed with mental illness or mental health conditions? ☐ Yes ☐No If yes, what illness?
Have you ever received counseling, medication, or hospitalization for mental health problems (to include outpatient treatment)? Are you currently on medications for mental health? ☐Yes ☐No If yes, what are they? If yes, explain.
Do you have a history of self-injurious behavior? ☐Yes ☐No If yes: ☐Cutting ☐Self-mutilation ☐Other Most recent date:
Have you ever tried to kill or harm yourself? ☐Yes ☐No
Do you have a history of assaulting or attacking others? ☐Yes ☐No (optional)
Do you know someone in this facility whom you wish to attack or harm? ☐Yes ☐No (optional) If yes, who is this person?
Do you now or have you ever heard voices that other people don't hear, seen things or people that others don't see, or felt others were trying to harm you for no logical or apparent reason? ☐Yes ☐No If yes, explain:

*** If Yes to questions in mental health section, make referral to mental health immediately**

-Substance Use/Abuse Screening

Have you ever been treated for drug and/or alcohol problems? ☐Yes ☐No
Have you ever suffered withdrawal symptoms from drug and/or alcohol use? ☐Yes ☐No
Are you able to stop using drugs and alcohol if you want? ☐Yes ☐No
Have you ever blacked out or experienced memory loss from drinking or drug use? ☐Yes ☐No

Have drug or alcohol use negatively impacted your life (family, work, relationships, criminal charges)? ☐Yes ☐No
If yes to any of the above questions, explain:
In the past three months, have you used tobacco, alcohol, illegal drugs, or misused prescription drugs? ☐Yes ☐No
If Yes, complete the following table and refer for follow-up and appropriate treatment as necessary.

Substance Used/ Route of Use	*Amount/Quantity Last Used*	*Date of Last Use*

Trauma History Screening

Have you had a physical or emotional trauma due to abuse or victimization? ☐Yes ☐No
Have you ever experienced, witnessed or been confronted with an event that involved actual or threatened death or serious injury (can include domestic violence, sexual assault, robbery, natural disaster, war, serious illness, terrorism). ☐Yes ☐No If yes, answer the following • Was your response to this event intense fear, helplessness or horror? ☐No ☐Some ☐Moderate ☐Extreme • Has this experience caused significant distress or impairment in your life? ☐No ☐Some ☐Moderate ☐Extreme • Has it affected your interpersonal relationships, work or other areas? ☐No ☐Some ☐Moderate ☐Extreme • Is this experience currently causing significant distress or impairment in your life? ☐No ☐Some ☐Moderate ☐Extreme
Have you ever been a victim of physical or sexual abuse or assault? ☐Yes ☐No If yes, explain:
Do you feel that you are in danger of being physically assaulted while you are here at the facility? ☐Yes ☐No If yes, explain:
Have you ever sexually assaulted or abused another person? ☐Yes ☐No If yes, explain:

If yes, refer to medical or mental health evaluation as appropriate.

Objective

Does the individual appear to have abnormal physical, mental, and/or emotion characteristics: ☐Yes ☐No Explain:
Does the individual appear to have barriers to communication. ☐Yes ☐No Explain:
Individual is orientated to: **Person** ☐Yes ☐No **Place** ☐Yes ☐No **Time** ☐Yes ☐No
If you observe any of the following, check the appropriate box and document findings below: Appearance: ☐Sweating ☐Shaking/tremors ☐Anxious ☐Disheveled ☐Ill appearance Findings:
Behavior: ☐Disorderly ☐Appropriate ☐Insensible ☐Agitation ☐Inability to focus/concentrate Findings:
State of Consciousness: ☐Alert ☐Responsive ☐Lethargic Findings:
Ease of Movement: ☐Body Deformities ☐Gait Findings:
Breathing: ☐Difficulty with breathing ☐Persistent cough ☐Hyperventilation Findings:
Skin: ☐Lesions ☐Jaundice ☐Rashes ☐Infestations ☐Nits (lice) ☐Bruises ☐Scars ☐Tattoos ☐Needle Marks or Indications of Drug Use Findings:
Developmental or physical disabilities: ☐Developmental Delay ☐Para/quadriplegia ☐Stroke ☐Amputation Findings:
Assistive Devices: ☐Glasses/Contacts ☐Hearing Aid(s) ☐Denture(s)/partial(s) ☐Orthopedic Brace ☐Prosthetic ☐Cane ☐Wheelchair ☐ Walker Findings:
☐None Observed
Comments/Other Findings: