STATE OF CT DEPARTMENT OF PUBLIC HEALTH
REFUGEE AND IMMIGRANT HEALTH PROGRAM
410 CAPITOL AVENUE, MS #11-TUB
P.O. BOX 340308
HARTFORD, CT 06134-0308
VOICE: (860) 509-7722
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INITIAL REFUGEE HEALTH ASSESSMENT FORM

Released 1/25/2013

ALIEN #:	DATE OF HEALTH ASSESSMENT: MM DD YYYY
PATIENT'S NAME: LAST, FIRST, MIDDLE	SEX: ☐ M ☐ F
	DATE OF BIRTH: MM DD YYYY
STREET ADDRESS:	CITY: / STATE: / ZIP:
	HOME TELEPHONE:
RACE (PLEASE CHECK ALL THAT APPLY): ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE	ETHNIC ORIGIN: ☐ HISPANIC ☐ NON-HISPANIC / COUNTRY OF BIRTH:
	U.S. ENTRY DATE: MM DD YYYY
LANGUAGE INTERPRETATION NEEDED? ☐ YES ☐ NO PREFERRED LANGUAGE _____ LANGUAGE USED DURING ASSESSMENT _____	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. FOR POLIO: NUMBER OF OVERSEAS DOSES ON OVERSEAS DOCUMENTS (1, 2, 3, NONE).
4. IF VACCINATED IN U.S., NOTE FULL DATE (MM/DD/YYYY)

	IS PERSON IMMUNE?	MM/DD/YYYY	MM/DD/YYYY
MEASLES	Y N I		
MUMPS	Y N I		
RUBELLA	Y N I		
DIPHTHERIA, TETANUS, AND PERTUSSIS	Y N I		
DIPHTHERIA – TETANUS	Y N I		
POLIO	1 2 3 NONE		
HEPATITIS B	Y N I		
HEPATITIS A	Y N I		
VARICELLA	Y N I		

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

IMMUNIZATION CATCH-UP SCHEDULE BEGUN? ☐ YES ☐ NO

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

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)

HBV

HBsAg	☐ NEGATIVE ☐ POSITIVE [IF POSITIVE, PATIENT IS INFECTIOUS]	☐ INDETERMINATE	☐ RESULTS PENDING	REFERRED FOR FOLLOW-UP? ☐ YES ☐ NO
ANTI-HBs	☐ NEGATIVE ☐ POSITIVE [IF POSITIVE, PATIENT IS IMMUNE]	☐ INDETERMINATE	☐ RESULTS PENDING	APPOINTMENT DATE: MM DD YYYY
ANTI-HBc	☐ NEGATIVE ☐ POSITIVE	☐ INDETERMINATE	☐ RESULTS PENDING	

HCV (ONLY FOR REFUGEES IN HIGH-RISK GROUPS. SEE CDC GUIDELINES) ☐ NEGATIVE ☐ POSITIVE ☐ INDETERMINATE ☐ RESULTS PENDING

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PATIENT'S NAME: LAST, FIRST, MIDDLE

HIV/ SEXUALLY TRANSMITTED INFECTIONS/ DISEASES

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

☐ NEGATIVE ☐ POSITIVE IF POSITIVE, 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

LABORATORY TESTS; LEAD SCREENING

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

LEAD SCREENING (TEST ALL CHILDREN 6 MOS. TO 17 YRS. OLD) ☐ YES ☐ NO ☐ RESULTS PENDING RESULT (#): _____ ☐ VENOUS ☐ CAPILLARY

CBC WITH 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)

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

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

MALARIA SCREENING ☐ YES ☐ NO ☐ RESULTS PENDING ☐ NO MALARIA SPECIES FOUND ☐ MALARIA SPECIES FOUND _____

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 SCREENINGS CONDUCTED:

DENTAL	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
HEARING	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
VISION	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
NUTRITION/VITAMIN LEVELS	☐ YES	☐ NO	☐ PENDING	☐ REFERRED
PREGNANCY	☐ YES	☐ NO	☐ PENDING	☐ REFERRED

OTHER REFERRALS (CHECK ALL THAT APPLY):

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

☐ WOMEN'S HEALTH ☐ NEWBORN SCREENING ☐ PRENATAL CARE

☐ NUTRITION/VITAMINS ☐ HYPERTENSION ☐ DIABETES

☐ HEALTH EDUCATION ☐ PARASITOLOGY ☐ PAIN

OTHER: _____

_____

COMMENTS / OTHER CONCERNS:

PHYSICIAN'S NAME: LAST, FIRST	FACILITY NAME:	
ADDRESS: (STREET, CITY, STATE, ZIP)	TELEPHONE:	FAX:
PERSON COMPLETING REPORT	DATE OF THIS REPORT: MM DD YYYY	

PLEASE SEND COMPLETED FORM TO: DEPARTMENT OF PUBLIC HEALTH, REFUGEE AND IMMIGRANT HEALTH PROGRAM, 410 CAPITOL AVE. MS#11TUB, P.O.BOX 340308, HARTFORD, CT 06134-0308; CONFIDENTIAL FAX: 860-509-8271