

**Name** (last, first, middle): \_\_\_\_\_  
**Date of Birth** (month, day, year) : (\_\_\_/\_\_\_/\_\_\_)  
**Alien or Visa Registration #**: \_\_\_\_\_  
**U.S. Arrival Date**: (month, day, year): \_\_\_/\_\_\_/\_\_\_\_\_  
**TB Class A or B Status**: \_\_\_\_\_  
**Secondary Migrant**:  Yes  No  if "Yes" from \_\_\_\_\_ State and to \_\_\_\_\_, Date \_\_\_/\_\_\_/\_\_\_\_\_  
**Date of First Clinic Visit for Screening** (month, day, year): \_\_\_/\_\_\_/\_\_\_\_

**Arrival Status**: \_\_\_\_\_  
**Gender**: \_\_\_\_\_  
**Volag**: \_\_\_\_\_  
**Country of Origin**: \_\_\_\_\_  
**Clinic Appointment Date**: \_\_\_/\_\_\_/\_\_\_

**Immunization Record**: Review overseas medical exam (OF-157) if available, and document immunization dates. For measles, mumps, rubella, and varicella: indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease. For all other immunizations: update series, or begin primary series if no immunization dates are found.

**Overseas immunizations done**

Vaccine-Preventable Disease/ Immunization	T if there is lab evidence of immunity; immunization not needed	Immunization Date(s)					
		Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Measles							
Mumps							
Rubella							
Varicella (VZV)							
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)							
Diphtheria-Tetanus (Td, Tdap)							
Polio (IPV, OPV)							
Hepatitis B (HBV)							
Haemophilus influenzae type b (Hib)							
Hepatitis A							
Influenza							
Pneumococcal							
BCG <input type="checkbox"/> Yes-Date(s) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown							

### Tuberculosis Screening:

Tuberculin Skin Test (TST) (regardless of BCG history)	Chest X-Ray – done in U.S. (If TST or QFT or T-STOP positive or symptomatic)	Diagnosis (must check one)	Treatment (for TB disease or LTBI)
____ mm Induration (not redness) <input type="checkbox"/> Past history of positive TST (66) <input type="checkbox"/> Given, not read (77) <input type="checkbox"/> Declined test (88) <input type="checkbox"/> Not done (99) <b>QuantiFERON TB (QFT) Test Or T-STOP Test</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, stable, old or healed TB <input type="checkbox"/> Abnormal, cavitory <input type="checkbox"/> Abnormal, non-cavitory, consistent with active TB <input type="checkbox"/> Abnormal, not consistent with active TB <input type="checkbox"/> Pending <input type="checkbox"/> Declined CXR <input type="checkbox"/> Not done <input type="checkbox"/> Done at other State	<input type="checkbox"/> No TB infection or disease <input type="checkbox"/> Latent TB Infection (LTBI)* <input type="checkbox"/> Old, healed <u>not</u> prev. Tx TB* <input type="checkbox"/> Old, healed prev. Tx TB <input type="checkbox"/> Active TB disease – (suspected or confirmed)* <input type="checkbox"/> Pending <input type="checkbox"/> Incomplete eval., lost to F/U *Complete TB treatment section	<b>Start Date:</b> ___/___/___ <b>or Reason for not treating</b> <input type="checkbox"/> Completed Tx overseas <input type="checkbox"/> Declined treatment <input type="checkbox"/> Medically contraindicated <input type="checkbox"/> Moved out of PA <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Further eval. pending <input type="checkbox"/> Other: _____

*TB treatment follow-up clinic if not the same as screening*

### Hepatitis B Screening:

1. Anti-HBs (✓ one)  Negative  Positive; *Note if positive, patient is immune.*  Indeterminate  Results pending  
 2. HBsAg (✓ one)  Negative  Positive\*  Indeterminate  Results pending  
*\*Note: if positive HBsAg, patient is infected with HBV and infectious to contacts. It is especially important to screen all household contacts.*  
 If positive HBsAg, were all household contacts screened?  Yes → were all susceptibles started on vaccine? \_\_\_ Yes \_\_\_ No  
 Contacts not screened → why not? \_\_\_\_\_  
 3. Anti-HBc (✓ one)  Negative  Positive  Results pending  Not done

### Sexually Transmitted Infections: (check one for each of the following)

1. Syphilis  Negative  Positive; treated: \_\_\_yes\_\_\_no  Results pending  Not done, why not? \_\_\_\_\_  
 2. Gonorrhea  Negative  Positive; treated: \_\_\_yes\_\_\_no  Results pending  Not done, why not? \_\_\_\_\_  
 3. Chlamydia  Negative  Positive; treated: \_\_\_yes\_\_\_no  Results pending  Not done, why not? \_\_\_\_\_  
 4. HIV  Negative  Positive; referred to specialist? \_\_\_yes\_\_\_no  Not done, why not? \_\_\_\_\_  
 5. Other, specify: \_\_\_\_\_  Negative  Positive; treated? \_\_\_yes\_\_\_no  Results pending

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**Intestinal Parasite Screening:**

**1. Was screening for parasites done?** (check one)

- Not screened for parasites; why not? \_\_\_\_\_
- Screened, results pending
- Screened, no parasites found
- Screened, non-pathogenic parasites found
- Screened, pathogenic parasite(s) found: (check all that apply)

<input type="checkbox"/> <b>Ascaris</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> <b>Paragonimus</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Clonorchis</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> <b>Schistosoma</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Entamoeba histolytica</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> <b>Strongyloides</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Giardia</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> <b>Trichuris</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Hookworm</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> <b>Other, (specify):</b>	Treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If not why \_\_\_\_\_

- 2. CBC with differential done?**  Yes  No, If yes, was Eosinophilia present?  Yes  No  Results pending
- If yes, was Anemia present?  Yes  No, If yes, further evaluation done?  Yes  No
- 3. Urinalysis done?**  Yes  No, If yes, was Schistosoma detected?  Yes  No
- Result pending If yes, further evaluation done?  Yes  No

**Currently Pregnant:** (check one)  Yes  No  No test done

**Malaria Screening:** (check one)

- Not screened for malaria; (e.g., No symptoms and history not suspicious of malaria)  Screened, results pending
- Screened, no malaria species found in blood smears
- Screened, malaria species found (please specify): \_\_\_\_\_
- If malaria species found: Treated?  Yes  No; Referred for malaria treatment?  Yes  No
- If referred for malaria treatment, specify physician/clinic: \_\_\_\_\_

**Mental Health Screening**

- 1. overseas medical documents indicate a diagnosis of mental illness:  Yes  No If "Yes", Treated  Yes  No
- Referred for further action:  Yes  No
- 2 List the diagnosis or symptoms that indicate a past or current psychiatric or mental illness:

\_\_\_\_\_  
\_\_\_\_\_

**3. Mental health screening review** (check (✓) the appropriate box for each question:

- 3.1 Are there physical signs of maltreatment \_scar, deformities)? Yes  No
- 3.2 Are there physical evidence of cultural practices (burn sticks, scarification)? Yes  No
- 3.2 Did the refugee become unusually anxious or agitated during the physical exam? Yes  No  If yes, please provide details: \_\_\_\_\_

Questions that can be ask at different points during screening:

- 3.3 Trouble Sleeping? Yes  No  b. Have you experienced any nightmares? Yes  No
- 3.4 a. Feeling tried? Yes  No  c. Were you ever exposed to a stressful or traumatic event? (link it to questions or conversation about Refugee camps can make this question less stressful) Yes  No
- 3.5 Have you noticed any change in your appetite (increase or decrease) with weight change? Yes  No
- 3.6 If the refugee is a child, ask the parent the following:
  - a. Is the child developing normally? Yes  No
  - If "no" provide details of the problem \_\_\_\_\_
  - b. If school-aged, has the child been attending school? Yes  No
  - If yes, highest grade or school level attained \_\_\_\_\_
  - c. Does the child have a history of learning difficulties? Yes  No  if yes, refer \_\_\_\_\_

3.7 Provide a brief history of the refugee's migration from their homeland:

\_\_\_\_\_  
\_\_\_\_\_

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**4. Mental health questions to be asked of the refugee:**

4.1 Have you previously had:

- a. Any behavioral or mental health treatments or interventions Yes  No   
b. Been given a psychological or psychiatric diagnosis? Yes  No

- if "Yes" was it : Mood disorders (Depression, Bipolar) Yes  No   
Psychotic disorders (Schizophrenia) Yes  No   
Anxiety Disorders (Phobias, Panic attacks, etc) Yes  No   
Autism Yes  No   
Mental retardation or Learning Disabilities Yes  No   
Alzheimer's Yes  No   
Substance abuse (drugs, alcohol, or other) Yes  No   
History of child abuse Yes  No   
If "yes" to any of the above, what was the treatment? \_\_\_\_\_

- c. Is follow-up or current treatment needed? Yes  No   
If "yes" indicate whether referral was made and to where: \_\_\_\_\_

4.2 In the last 6 months, have you experienced any of the following: intrusive memories, nightmares, appetite or sleep disturbance, fatigue, irritability, high level of anxiety or agitation, anger, avoidance of memories, etc.? Yes  No   
If "yes", please describe the symptoms experienced: \_\_\_\_\_

4.3 Are you currently experiencing disturbance of sleep, appetite, suicidal ideation or any other feeling or behavior you are concerned about? Yes  No

4.4 Are you willing or interested in speaking with a mental health professional? Yes  No

**5. If the refugee appears to have any significant mental or behavioral problems they should receive an emergency psychiatric evaluation. If required,**

Please state the name and date of the of the referral:

Referral place: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**6. While completing the medical examination and history, the examining practitioner should ask the following Post-Traumatic Stress Disorder and Behavioral Health Questions to the refugee:**

6.1 How would you rate your current health?: Excellent  Very good  Good  Fair or Poor

6.2 Have you had life-threatening or violent experiences (e.g., torture, war trauma, witnessed violent deaths, etc.)? If yes:  
a. Are you still suffering from any these experiences? Yes  No  if "yes" refer

Please state referral place and date if deemed necessary: \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Alien or Visa Registration # \_\_\_\_\_

Please fill in for all refugees:

HEMOGLOBIN	HEMATOCRIT %	LEAD (only for <16 yrs old)
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Referrals: (check all that apply)

<input type="checkbox"/> Primary Care Provider	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Hearing	<input type="checkbox"/> Family Planning
<input type="checkbox"/> WIC	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> GI	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Urology
<input type="checkbox"/> General Medicine	<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Neurology
<input type="checkbox"/> Ear, Nose & Throat (ENT)	<input type="checkbox"/> Family Practice	<input type="checkbox"/> State or Local Health Department:
<input type="checkbox"/> Hematology	<input type="checkbox"/> Other Referral _____	

Interpreter needed:  Yes, language(s) needed: \_\_\_\_\_  No

**Note:** Fill out the Pennsylvania Refugee Health Assessment Form indicating the results of the tests listed on this form and return to the local public health agency noted below within 30 days of receipt.  
For more information, contact the Refugee Health Program, Pennsylvania Department of Health at: (717) 787-3350 or (717)-265-8879.

Screening Clinic \_\_\_\_\_ Physician/PA/NP (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Name/title person completing form \_\_\_\_\_ Date screening completed \_\_\_\_/\_\_\_\_/\_\_\_\_

FAX COMPLETED FORM TO THE PADOH AT (717) 772-6975 – ATTN: REFUGEE HEALTH COORDINATOR

**Pennsylvania Department of Health Initial Communicable Disease Health Screening Tests  
Recommended for All Refugees/Immigrants**

<b>Disease or Condition</b>	<b>Screening Recommendations</b>
<b>Immunizations</b>	Assess and update immunizations for each individual. For measles, mumps, rubella, and varicella: indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease. For all other immunizations: update series, or begin primary series if no immunization dates are found. If you need assistance translating immunization records or determining needed immunizations, call the PADOH at (717) 787-3350. Always update the personal immunization record card.
<b>Tuberculosis (TB)</b>	<p><b>Perform a tuberculin skin test (TST) or QuantiFERON TB (QFT) for all individuals regardless of BCG history</b>, unless documented previous positive test. Pregnancy is not a medical contraindication for TST testing or for treatment of active or latent TB. TST administered prior to 6 months of age may yield false negative results.</p> <ul style="list-style-type: none"> <li>• A chest x-ray should be performed for all individuals with a positive TST or QFT test.</li> <li>• A chest x-ray should also be performed <u>regardless of TST results</u> for: <ul style="list-style-type: none"> <li>○ those with a TB Class A or B designation from overseas exam, and</li> <li>○ those who have symptoms compatible with TB disease.</li> </ul> </li> </ul>
<b>Hepatitis B</b>	<b>Administer a hepatitis B screening panel</b> including hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (anti-HBs), and hepatitis B core antibody (anti-HBc) to all adults and children. Vaccinate previously unvaccinated and susceptible children, 0-18 years of age. Refer all persons with chronic HBV infection for additional ongoing medical evaluation. Vaccinate susceptible adults at increased risk for HBV infection.
<b>Intestinal Parasites</b>	<b>Evaluate for eosinophilia by obtaining a CBC with differential and conduct stool examinations for ova</b> and parasites; two stool specimens should be obtained more than 24 hours apart. If parasites are identified, one stool specimen should be submitted 2-3 weeks after completion of therapy to determine response to treatment. Eosinophilia requires further evaluation for pathogenic parasites, even with two negative screening stool examinations.
<b>Sexually Transmitted Infections</b>	<b>Screen for syphilis by administering VDRL or RPR. Confirm positive VDRL or RPR by FTA-ABS/MHATP</b> or other confirmatory test. Repeat VDRL/FTA in 2 weeks if lesions typical of primary syphilis are noted and person is sero-negative on initial screening. <i>Use your clinical judgment to screen for chlamydia and gonorrhea using urine testing if possible.</i> Screen for HIV and other STDs if indicated by self-report or endemicity in homeland
<b>Malaria</b>	<b>Screen those refugees who present with symptoms suspicious of malaria.</b> For <i>asymptomatic refugees from highly endemic areas, i.e., sub-Saharan Africa</i> , screen or presumptively treat if no documented pre-departure therapy (note contraindications for pregnant or lactating women and children < 5 kg).
<b>Lead</b>	Venous blood lead level (BLL) screening is recommended for all refugee children under 16 years. An elevated blood lead test is a result $\geq 10\mu\text{g}/\text{dl}$ of blood. Depending on blood lead level, follow-up testing and appropriate management may be needed.

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## Other Recommended Health Issues to Consider

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### **Health Problems**

Hematologic disorders (eosinophilia, anemia, microcytosis), dental caries, nutritional deficiencies, thyroid disease, otorhinologic and ophthalmologic problems, history of trauma, dermatologic abnormalities.

### **Screening**

CBC, serum chemistry profiles, urinalysis, height, weight, vision and hearing evaluation and blood pressure. Assess mental health needs (e.g., headaches, nightmares, depression). Refer to other health resources as needed.

### **Victim of Human Trafficking**

Human trafficking is a form of modern-day slavery and is a crime against humanity. Victims of human trafficking are young children, teenagers, men and women. Approximately 600,000 to 800,000 victims annually are trafficked across international borders world wide. Victims of human trafficking are subjected to force, fraud, or coercion, for the purpose of sexual exploitation or forced labor.

**A victim of trafficking may look like many of the people you help every day. You can help trafficking victims get the assistance they need by looking beneath the surface for the following clues: Evidence of being controlled**

- Evidence of an inability to move or leave job
- Bruises or other signs of battering
- Fear or depression
- Non-English speaking
- Recently brought to this country from Eastern Europe, Asia, Latin America, Canada, Africa or India
- Lack of passport, immigration or identification documentation

## **MENTAL HEALTH SCREENING**

### **General instructions:**

- Before performing an interview, it is important to explain that all information obtained through this interview is part of the confidential medical record and will not be shared or disclosed (except with the State Refugee Health Program) without the written permission and consultation with the refugee. The interviewer is free not to answer any of the questions if they so chose. Failure to answer the questions will not impact the ability to get other services through the Refugee Health Program or the Pennsylvania Department of Health.
- For refugees under the age of 16 years, the questions should be answered by the parent or guardian if available.
- A separate form should be completed for each refugee, including children.

### **Review of Overseas Medical Documents**

- Available medical records should be reviewed for evidence of a past history of mental illness or psychiatric diagnosis. The questions in part 1 should be answered based on the information found in these records, including diagnosis of mental illness, psychiatric conditions, hospitalization or institutionalization for these conditions. The clinicians must also determine whether there is a history of harmful behavior, a diagnosis of a physical or mental disorder with which harmful behavior may be associated or in which harmful behavior is an element of the diagnostic criteria, evidence of nonmedical use of psychoactive substances, or evidence of alcohol use or dependence (CDC, Alien Medical examination Technical Instruction, 2009)
- Other information available in the medical records of from the refugee may suggest a higher likelihood of mental health or psychiatric problems. This includes a history of head trauma, loss of consciousness and seizures, and a history of victimization due to violence. Such a history may indicate ongoing needs or raise suspicions for previously undiagnosed conditions, such as Traumatic Brain Injury (TBI).
- Child development is another important indicator of risk for mental health or psychiatric problems. For children under the age of 16 years, the parent should be asked whether the child has been developing normally, whether the child has been attending school (if school aged) and to what level, and whether there is a history of learning difficulties.

A brief history of each family's migration from their homeland to the U.S. should be obtained; this may help further assess the need for mental health intervention or assistance.

**Physical examination:**

- The physical examination can provide clues to a history of physical or mental abuse that could indicate a greater need for mental health assistance or referral. As part of the overall health examination, the provider or practitioner should look for physical signs of maltreatment, such as scars and other deformities. The clinician or practitioners should be able to differentiate traditional medical or cultural practices during a physical examination (e.g. burn sticks, scarification) from other types of maltreatment and abuse.
- Throughout the screening process, staff should pay close attention to the refugees' level of anxiety. This assessment can be made based on the tone of voice, body language, and behavior that may be indicative of higher levels of anxiety than expected for health screening process. This may suggest a need for mental health intervention.

**Mental Health Questions based on specific conditions and history** – These questions should be asked of the refugee (or their parent or guardian) as part of the mental health assessment.

Affirmative answers to any of the questions in 4.1 should prompt a referral for mental health services. The need for immediate intervention or referral should be determined by the examining clinician or practitioner.

The questions in part 4.2 concerning family history may provide clues regarding the likelihood the refugee has a mental health problem or is likely to have one in the future. Immediate family members refer to siblings, children, parents, aunts and uncles, and grandparents.

**Secondary Migrant (refugee):** is one who moves to a different location in the United States after initial resettlement. The State Refugee Health Program is responsible for the coordination of transfers between states and designated Counties/jurisdictions within the state. The local health care providers should notify the State Refugee Health Program when a patient moves, plans or requests to transfer to a secondary state. The local Voluntary Resettlement Agencies (VOLAGs) are often the primary source for the refugees' new contact information; local health care providers should gather this information from the VOLAGs. It is important to register date of transfer, initial Resettlement State as well as when a refugee move from Pennsylvania too.

All transfers should be made using a secure transfer system that can maintain the individual confidentiality rule and regulation. Emailing individual medical information without precaution is not advisable.

**Fax or mail all completed form to PA DOH, Refugee Health Program Section**

***For questions or further information on refugee mental health assessments, please call the Refugee Health Program, PA Department of Health, Division of Infectious Disease Epidemiology at (717)783-8358 or (717)265-8879***

**STATEMENT OF RIGHTS**

*Information on this form is collected for the Pennsylvania Department of Health (PA DOH), by authority of Section 412(c)(3) of the Immigration and Nationality Act as amended by the Refugee Act of 1980. In order to provide services, it may be necessary to release information from the patient's record to individuals or agencies who are involved in the care of the individual. Such individuals and agencies usually include family physicians and/or dentists, medical and dental specialists, public health agencies, hospitals, schools, and day care centers. All public health agencies, health institutions, or providers to whom the refugee has appeared for treatment or services shall be entitled to the information included on this form.*

*Revised 04/2012*

