Maine Refugee Health Assessment

After completion, return form to the Office of Maine Refugee Services
EHR exports and labs may be attached in lieu of completing fields

State Refugee Health Coordinator
Office of Maine Refugee Services
307 Congress St. PO Box 10660
Portland ME, 04101
email: OMRSHealthTeam@ccmaine.org

Name Last:________________________ Name First: _______________________M.I.______	Date of Birth: ___/___/____	Gender: ☐ Male ☐ Female ☐ Transgender
Alien #:	US Arrival Date: ___/___/____	Country of Origin:_____________ Refugee Camp:_______________

Class A status: _____________________ ☐ No ☐ Yes (requires approved waiver for US entry and **immediate** follow-up upon arrival)	Dates of Clinical Visit (s) for Screening Screening Visit #1: ___/___/____(date) Screening Visit #2: ___/___/____(date)
Class B TB status: _____________________ ☐ No ☐ Yes (requires follow-up soon after arrival)	Class B Other / Specify:_______________________ ☐ No ☐ Yes (requires follow-up **soon** after arrival)

Interpreter Needed: ☐ No ☐ Yes, language ___________ ☐ Professional interpreter_____________(name)

Secondary Migrant: ☐ No ☐ Yes Prior state: ________________________________	Asylee: ☐ No ☐ Yes Certified Victim of Trafficking: ☐ No ☐ Yes

Consent for Treatment:
I consent to examination, diagnostic testing (which may include TB, hepatitis B, HIV, CBC), and treatment services provided by ___________________. Signature:_________________________ Date___/___/____

Vital Signs

Height (in.):	Weight (lbs.):	Head Circum (in.):	BMI:
Pulse:	Blood Pressure:	Respirations:	Temperature (F°):
Vision Screening: OD___/20 OS___/20		Hearing Screen: ☐ Normal ☐ Abnormal	

Past Medical History

Current Medications: ☐None ☐ Yes (list / attach) ____
Medication Allergies: ☐ None ☐ Yes (list / attach) ____
Herbal/Traditional treatments: ☐ None ☐ Yes (list / attach) _______________________________________

Tobacco / betel nut use: ☐ Yes ☐ No	Alcohol/ drug use: ☐ Yes ☐ No
Vision problems: ☐ Yes ☐ No	Gastrointestinal: ☐ Yes ☐ No
Hearing problems: ☐ Yes ☐ No	Genitourinary: ☐ Yes ☐ No
Dental problems: ☐ Yes ☐ No	Skin: ☐ Yes ☐ No
Respiratory: ☐ Yes ☐ No	Mental Health Concern: ☐ Yes ☐ No
Cardiovascular: ☐ Yes ☐ No	Neurological/Seizures: ☐ Yes ☐ No
Musculoskeletal: ☐ Yes ☐ No	Endocrine: ☐ Yes ☐ No
Pregnant: ☐ Yes EDD: _______☐ No LMP: ______ G:_______ P:__________AB:__________	Other:_____________________________________

Review of Systems

	NL	Description		NL	Description
Constitutional Symptoms			GI		
Eyes			GU/GYN		
Ears, Nose, Mouth, Throat			Integumentary		
Respiratory			Mental Health		
Cardiovascular			Neurological		
MS			Endocrine		
Allergic, Immunologic			Hematologic, Lymphatic		

Physical Exam Pallor___? Hepatosplenomegaly___? Lymphadenopathy___? Nutrition___?					
	NL	Description		NL	Description
HEENT			GI/Rectal		
Neck			Breasts /GU		
Respiratory			Abdomen		
Cardiovascular			Skin and SQ		
Musculoskeletal			Back		
Extremities			Neuro		

Immunizations: *If serological immunity is determined, indicate and attach labs*						
NOTE: CDC recommends revaccination rather than testing for immunity in most cases (see provider handbook)						
	mm/dd/yr	mm/dd/yr	mm/dd/yr	mm/dd/yr	mm/dd/yr	mm/dd/yr
COVID-19 Vaccine administration						
Measles						
Mumps						
Rubella						
Varicella (VZV)						
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT) *Please Circle One*						
Diphtheria-Tetanus (Td, Tdap) *Circle One*						
Polio (IPV, OPV) *Please Circle One*						
Hepatitis B (HBV)						
Hepatitis A						
Meningococcal conjugate (MCV)						
Haemophilus influenzae type b (Hib)						
Influenza						
Pneumococcal						
Human Papilloma Virus (HPV)						
Zoster (shingles)						

Tuberculosis Screening Exposure to TB__? Cough__? Night Sweats__? Received BCG Vaccine___?	
Interferon-Gamma Release Assays (IGRAs) ***NOTE**: TST is preferred for testing children aged <5 years old.* □ Not done □ Positive □ Borderline ___/___/____(date) □ Negative □ Indeterminate	Tuberculin Skin Test (TST) _____mm induration ___/___/____(plant date) ___/___/____(read date) □ Not done □ Given, not read □ Positive □ Past history of positive TB □ Negative
Chest X-ray (If TST, IGRA positive, Class B or Symptomatic) ___/___/____(date) □ Normal □ Abnormal, referred to TB Program □ Abnormal, not TB □ Not done □ Refused	Diagnosis (**must** check one) □ No TB infection or disease □ Latent TB infection (LTBI), referred to TB program or patient's primary care provider for follow-up ___/___/____(date) □ Active TB disease, referred to TB program for evaluation and treatment. ___/___/____(date) □ Old, healed, previously treated

Hepatitis B Screening

Screened?	Diagnosis (**must** check one)
□ No □ Yes___/___/____(date) □HBsAb □HBsAg □HBcAb	□ Immune (HBsAb positive) □ Unvaccinated and susceptible (all negative); vaccinate □ Possible active (HBsAG or HBcAb positive), referred to PMD / specialist for follow-up ___/___/____(date) □ Pending

Pregnancy Test (Urine pregnancy test for all women of childbearing age)

Screened? □ Not Done □ Yes, ________(date) Results: □ Negative □ Positive

Syphilis Screening (VDRL / RPR) *Please Circle One*

□ Negative □ Positive; treated ___/___/____(date) or referred ___/___/____(date) □ Titer ____________
□ Not done

Chlamydia /Gonorrhea Screening (urine specimen)

Gonorrhea □ Negative □ Positive; treated ___/___/___ or referred ___/___/____(date) □ Not done
Chlamydia □ Negative □ Positive; treated ___/___/___ or referred ___/___/____(date) □ Not done

HIV Screening CDC recommends for all persons 13-64 years of age; children < 12 years of age should be screened unless the mother's HIV status can be confirmed as negative and the child is otherwise thought to be at low risk of infection (no history of high-risk exposures such as blood product transfusions, early sexual activity, or sexual abuse).

Screened? □ Yes, ___/___/____(date) □ Offered, but refused
Results: □ Negative □ N/A □ Positive, and referred to HIV/AIDS program ___/___/____(date)

CBC with Differential

Screened? □ Yes, __/___/___(date) □ Not done
WBC ______ RBC ______ Hemoglobin ______ HCT ______ MCV______ RDW ______ Platelet ______
Neutrophils _______ Lymphocytes _______ Monocytes _______ Baseophils _______ Eosinophils _______
Eosinophil %______ Eosinophilia present? □ Yes □ No □ N/A
Referred for further evaluation ___/___/____ (date)

Intestinal Parasite Screening

Pre-Departure presumptive treatment? □ Yes □ No □Unknown

□ O&P x1 ___/___/____(date) □ O&P x 2 ___/___/____(date)	□ Results Rec'd ___/___/____(date)	□ Domestic presumptive treatment	□ No parasites found

□ Serology test: (see population specific) □ Schistosoma □ Strongyloides

□ Parasites found, check all that apply below □ Treatment completed ___/___/____(date)	Referral for treatment? □ Yes ___/___/____(date) □ No; why not? _____________________

□ Ascaris	□ Clonorchis	□ Entamoeba histolytica
□ Giardia	□ Hookworm	□ Paragonimus
□ Schistosoma	□ Strongyloides	□ Tapeworm
□ Trichuris	□ Other (specify)	□ Other (specify)

Malaria Screening *See guidelines for presumptive treatment post-arrival*

Pre-Departure presumptive treatment? □ Yes □ No □Unknown
Domestic presumptive treatment? □ Yes □ No Malarial screening □ Yes □ No
Results □ Positive □ Negative Species: __________________ Treated □ Yes □ No

<table>
<tr><th colspan="4">Lead Screening (<17 yrs old)</th></tr>
<tr><td colspan="2">Screened? ☐ Yes ___/___/____(date) ☐ Not done
Results: ☐ Negative ☐ Positive ________
(elevated BLL ≥ 5 µg/dL)</td><td colspan="2">☐ NOTE: Re-check all children aged 6 mo- 6 yrs within 3-6 months of arrival, regardless of results of initial lead screen.</td></tr>
<tr><th colspan="4">Glucose and Lipids</th></tr>
<tr><td colspan="2">Glucose (mg/dL) ________</td><td colspan="2">Total Cholesterol ________ HDL ________ LDL _____________
Triglycerides ________</td></tr>
<tr><th colspan="4">Referrals: (check all that apply)</th></tr>
<tr><td colspan="4">☐ Primary care Reason ____</td></tr>
<tr><td>☐ Emergency/Urgent</td><td>☐ Dental</td><td>☐ Vision</td><td>☐ Mental Health ref to: ___________________</td></tr>
<tr><td>☐ WIC</td><td colspan="2">☐ Children with Special Health Care Needs</td><td>☐ Other____________________________</td></tr>
<tr><td colspan="4">☐ Vitamins recommended: ☐ Multivitamin ☐ Vitamin D ☐ Prenatal ☐ Population specific:
☐ Bhutanese, B12
☐ Other____________________</td></tr>
<tr><th colspan="4">Additional Labs and Screening</th></tr>
<tr><td colspan="4">☐ Population specific: Test for Vitamin B12 in Bhutanese with clinical manifestations suggestive of deficiency
☐ Infant metabolic screening in newborns, according to state guidelines
☐ In clinic settings allowing for follow up in primary care consider: cancer screening</td></tr>
</table>

Provider Name/Title	______/______/______ (date)

Health Screening Tests Recommended for All Refugees

Components of Refugee Health Assessment: Complete history, review of systems, physical examination including assessment for infectious disease and chronic disease, and laboratory testing. Infectious diseases continue to be significant and can be readily addressed when identified. There is increased recognition that chronic health disorders are common and may pose greater long-term threat to the individual's health.

Disease or Condition Screening Recommendations	
Immunizations	Assess and update immunizations for each individual; immunizations are not needed if immune. **CDC recommends revaccination rather than measuring titers for immunity in most cases. Please see provider handbook for further discussion.** Update series or begin primary series if immunization dates are not found. If you need assistance translating immunization records or determining needed immunizations, call CDC hotline 800-CDCINFO (1-800-232-4636). Always update the personal immunization record card.
Tuberculosis (TB)	Perform a QuantiFERON-TB gold test (QTB) for TB for all individuals ages greater than 2 years regardless of BCG history or previous tuberculin skin test (TST) result, unless documented previous positive QTB test. TST is preferred for testing children between ages of 6 months to under 2 years old. TST administered prior to 6 months of age may yield false negative results. Pregnancy is not a medical contraindication for QTB testing nor treatment of active TB. Regardless of suspicion of active TB, exposure, or plans to treat latent TB, QTB should always be drawn for pregnant women on presentation to care. It is general practice to delay treatment for latent tuberculosis infection while pregnant or breastfeeding, but this is determined on case-by-case basis at provider's discretion. • A chest x-ray should be performed for all individuals with a positive QTB test or TST. However, if pregnant and asymptomatic, this should be delayed until ideally mid-2nd trimester, but should still be completed. If pregnant and symptomatic, requires CXR regardless of gestational age. • A chest x-ray should be performed regardless of QTB or TST result for o those with TB Class A or B1 designation from overseas exam or o those who have symptoms compatible with active TB disease.
Hepatitis B	Administer a **hepatitis B screening panel** 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. Vaccinate susceptible adults at increased risk for HBV infection (due to close interaction within their communities) or from endemic countries. Refer all persons with chronic HBV infection for additional ongoing medical evaluation. Consider vaccination in individuals with any chronic liver disease (e.g. hepatitis C).
Sexually Transmitted Infections	Routine screening for HIV, ages 13- 64 years; children <12 years of age should be screened unless the mother's HIV status can be confirmed as negative and the child is otherwise thought to be at low risk of infection (no history of high-risk exposures such as blood product transfusions, early sexual activity, or sexual abuse) using **Anti-HIV 1+2 assay**. Screen for syphilis by administering **VDRL or RPR**. Confirm positive VDRL or RPR by FTA-ABS/MHATP 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. Screen for chlamydia and gonorrhea using **urine specimen** if possible. Screen other STDs if indicated by self-report or endemicity in homeland.

Intestinal Parasites	For ***all*** refugee arrivals (asymptomatic and symptomatic): • Confirm specific pre-departure presumptive treatment • Evaluate for eosinophilia* by obtaining a **CBC with differential** (eosinophilia >400cells/µl) **PLUS** **Documented** pre-departure presumptive treatment For **single-dose** albendazole pre-departure treatment *(**no** praziquantel)* • **Strongyloides serology** (all refugees); • **Schistosoma serology** (sub-Saharan Africans); • Treat if positive for *Strongyloides stercoralis* or *Schistosoma spp.* • If positive for eosinophilia, re-check total eosinophil count in 3-6 months.** For **single-dose** albendazole pre-departure treatment ***with*** *praziquantel* • **Strongyloides serology** (all refugees); • Treat if positive for *Strongyloides stercoralis* • If positive for eosinophilia, re-check total eosinophil count in 3-6 months.** For **high-dose** pre-departure treatment *(ivermectin **and** praziquantel):* • If positive for eosinophilia, re-check total eosinophil count in 3-6 months after arrival. ** **No documented** pre-departure presumptive treatment: • Conduct **stool examinations** for ova and parasites (O&P); two stool specimens should be obtained more than 24 hours apart; • **Strongyloides serology** (all refugees); • **Schistosoma serology** (sub-Saharan Africans); • Treat pathogenic parasites; • Re-check total eosinophil count in 3-6 months.** *Eosinophilia may or may not be present with parasitic infection; an absolute eosinophil count provides supplemental diagnostic information. **** Persistent eosinophilia or symptoms requires further diagnostic evaluation.** If parasites are identified, one stool specimen should be submitted 2-3 weeks after completion of therapy to determine response to treatment. For background information and treatment guidelines see CDC's Evaluation of Refugees for Intestinal and Tissue-Invasive Parasitic Infections during Domestic Medical Examination, as well as The Medical Letter on Drugs and Therapeutics: Drugs for Parasitic Infections.
Malaria	Screen those refugees present with symptoms suspicious of malaria. For asymptomatic refugees from highly endemic areas, i.e., sub-Saharan Africa, screen or presumptively treat if no documented predeparture therapy (note contraindications for pregnant or lactating women and children < 5 kg)
Lead	**Venous blood lead level (BLL)** screening is recommended for all refugee children under 17 years. Check for lead sources in children with elevated BLL ≥10 µg/dL; check BLLs in all family members. Follow up management. Prescribe daily pediatric multivitamins with iron for refugee children 6 to 59 months of age.
Mental Health	Assess for signs of post traumatic stress, acute psychiatric disorders; assess mental health as reflected in general health and well being (e.g., sleeplessness, headaches, nightmares, irritability).
Lipids	Screen and treat men >= 35 years and women >= 45 years of age for lipid disorders by obtaining, at the minimum, total cholesterol and high-density lipoprotein levels. These can be checked in a nonfasting state. Screen and treat men 20-35 years and women 20-45 years of age if they have increased risk of coronary heart disease (diabetes, tobacco use, hypertension, family history of cvd before age 50 in male relatives or age 60 in female relatives, or a family history suggestive of familial hyperlipidemia.