

**Maine Refugee Health Assessment**

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

Clinic Name: _____		Office Visit Date: _____		Interpreter Needed: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Physician Name: _____		____/____/____		Language _____	
<b>Resettlement Agency/Sponsor:</b> _____				Phone #: _____	
Patient Name Last: _____		Date of Birth: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex	
Patient Name First: _____ M.I. _____		____/____/____		Gender: _____	
Alien #: _____		Immigration Status: _____			
Country of Origin: _____		US Arrival Date: _____		Secondary Migrant: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Host Country: _____		____/____/____		Prior state: _____	
Class B TB status: _____		Class B Other / Specify: _____			
<input type="checkbox"/> No <input type="checkbox"/> Yes (requires follow-up <b>soon</b> after arrival)		<input type="checkbox"/> No <input type="checkbox"/> Yes (requires follow-up <b>soon</b> after arrival)			
<b>Vital Signs</b>					
Height (in.): _____		Weight (lbs.): _____		Head Circum (in.): _____	
Pulse: _____		Blood Pressure: _____		BMI: _____	
Respirations: _____		Temperature (F°): _____			
Vision Screening: OD____/20 OS____/20			Hearing Screen: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
<b>Past Medical History</b>					
Current Medications: <input type="checkbox"/> None <input type="checkbox"/> Yes (list / attach) _____					
Medication Allergies: <input type="checkbox"/> None <input type="checkbox"/> Yes (list / attach) _____					
Herbal/Traditional treatments: <input type="checkbox"/> None <input type="checkbox"/> Yes (list / attach) _____					
Tobacco / betel nut use: <input type="checkbox"/> Yes <input type="checkbox"/> No			Alcohol/ drug use: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Vision problems: <input type="checkbox"/> Yes <input type="checkbox"/> No			Gastrointestinal: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hearing problems: <input type="checkbox"/> Yes <input type="checkbox"/> No			Genitourinary: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental problems: <input type="checkbox"/> Yes <input type="checkbox"/> No			Skin: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Respiratory: <input type="checkbox"/> Yes <input type="checkbox"/> No			Mental Health Concern: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Cardiovascular: <input type="checkbox"/> Yes <input type="checkbox"/> No			Neurological/Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Musculoskeletal: <input type="checkbox"/> Yes <input type="checkbox"/> No			Endocrine: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Pregnant: <input type="checkbox"/> Yes EDD: _____ <input type="checkbox"/> No LMP: _____			Other: _____		
G: _____ P: _____ AB: _____					
<b>Pregnancy Test</b> (Urine pregnancy test for all women of childbearing age)					
Screened? <input type="checkbox"/> Not Done <input type="checkbox"/> Yes, (date) _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive					
<b>Review of Systems</b>					
	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		

<b>Physical Exam</b> Pallor ___? Hepatosplenomegaly ___? Lymphadenopathy ___? Nutrition ___?					
	NL	Description		NL	Description
HEENT			GI/Rectal		
Neck			Breasts /GU		
Respiratory			Abdomen		
Cardiovascular			Skin and SQ		
Musculoskeletal			Back		
Extremities			Neuro		
<b>Immunizations:</b> <i>If serological immunity is determined, indicate and attach labs</i>					
<b>NOTE: CDC recommends revaccination rather than testing for immunity in most cases (see provider handbook)</b>					
	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) <i>Please Circle One</i>					
Diphtheria-Tetanus (Td, Tdap) <i>Circle One</i>					
Polio (IPV, OPV) <i>Please Circle One</i>					
Hepatitis B (HBV)					
Hepatitis A					
Meningococcal conjugate (MCV)					
Haemophilus influenzae type b (Hib)					
Influenza					
Pneumococcal					
Human Papilloma Virus (HPV)					
Zoster (shingles)					
<b>Hepatitis Screening Panel</b>					
Hep B Screened? <input type="checkbox"/> No <input type="checkbox"/> Yes ___/___/___(date) HBsAb <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate HBsAg <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate HBcAb <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate  Hep C Screened? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Anti-HCV <input type="checkbox"/> Negative <input type="checkbox"/> Positive* <input type="checkbox"/> Indeterminate *If Positive, screen for HCV-RNA			<b>Diagnosis (must check one)</b> <input type="checkbox"/> Immune (HBsAb positive) <input type="checkbox"/> Unvaccinated and susceptible (all negative); vaccinate <input type="checkbox"/> Possible active (HBsAG* or HBcAb positive), referred to PMD / specialist for follow-up ___/___/___(date) <input type="checkbox"/> Pending *If HBsAg Positive, Screen for anti-HDV <input type="checkbox"/> Negative <input type="checkbox"/> Positive (if Positive, screen for HDV-RNA)		
<b>Lead Screening (children &lt;17 yrs old and pregnant / lactating individuals)</b>					
Screened? <input type="checkbox"/> Yes ___/___/___(date) <input type="checkbox"/> No Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive _____ (elevated BLL ≥ 3.5 µg/dL )			<input type="checkbox"/> <b>NOTE:</b> Re-check all children aged 6 mo to 6 yrs within 3-6 months of arrival, regardless of results of initial lead screen.		

<b>Tuberculosis Screening</b> Exposure to TB ___? Cough ___? Night Sweats ___? Received BCG Vaccine ___?			
Interferon-Gamma Release Assays (IGRAs) <b>NOTE: TST is preferred for testing children aged &lt;2 years old.</b> <input type="checkbox"/> Not done <input type="checkbox"/> Positive <input type="checkbox"/> Borderline ___/___/___(date) <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	Tuberculin Skin Test (TST) ___mm induration ___/___/___(plant date) ___/___/___(read date) <input type="checkbox"/> Not done <input type="checkbox"/> Given, not read <input type="checkbox"/> Positive <input type="checkbox"/> Past history of positive TB <input type="checkbox"/> Negative		
Chest X-ray (If TST, IGRA positive, Class B or Symptomatic) ___/___/___(date) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, referred to TB Program <input type="checkbox"/> Abnormal, not TB <input type="checkbox"/> Not done <input type="checkbox"/> Refused	Diagnosis ( <b>must</b> check one) <input type="checkbox"/> No TB infection or disease <input type="checkbox"/> Latent TB infection (LTBI), referred to TB program or patient's primary care provider for follow-up ___/___/___(date) <input type="checkbox"/> Active TB disease, referred to TB program for evaluation and treatment. ___/___/___(date) <input type="checkbox"/> Old, healed, previously treated		
<b>Syphilis Screening (VDRL / RPR)</b>			
<input type="checkbox"/> Negative <input type="checkbox"/> Positive; treated ___/___/___(date) or referred ___/___/___(date) <input type="checkbox"/> Titer _____ <input type="checkbox"/> Not done			
<b>Chlamydia /Gonorrhea Screening (urine specimen)</b>			
Gonorrhea <input type="checkbox"/> Negative <input type="checkbox"/> Positive; treated ___/___/___ or referred ___/___/___(date) <input type="checkbox"/> Not done Chlamydia <input type="checkbox"/> Negative <input type="checkbox"/> Positive; treated ___/___/___ or referred ___/___/___(date) <input type="checkbox"/> Not done			
<b>HIV Screening</b> CDC recommends for all persons 13-64 years of age; children < 13 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). In most situations, complete risk information will not be available, and thus <b>most children &lt; 13 years of age should be screened.</b> Screening for ages >64 is also encouraged.			
Screened? <input type="checkbox"/> Yes, ___/___/___(date) <input type="checkbox"/> Offered, but refused Results: <input type="checkbox"/> Negative <input type="checkbox"/> N/A <input type="checkbox"/> Positive, and referred to HIV/AIDS program ___/___/___(date)			
<b>CBC with Differential</b>			
Screened? <input type="checkbox"/> Yes, ___/___/___(date) <input type="checkbox"/> Not done			
WBC	_____ K/uL	Neutrophils	_____ % Absolute _____ K/UL
RBC	_____ M/uL	Lymphocytes	_____ % Absolute _____ K/UL
Hemoglobin	_____ g/dL	Monocytes	_____ % Absolute _____ K/UL
Hematocrit	_____ %	Eosinophil	_____ % Absolute _____ K/UL
MCV	_____ FL	Basophils	_____ % Absolute _____ K/UL
MCH	_____ PG	Immature Granulocytes	_____ % Absolute _____ K/UL
MCHC	_____ g/dL		
RDW	_____ %	Eosinophilia present?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
PLATELET	_____ K/uL	Referred for further evaluation?	___/___/___(date)
<b>Glucose and Lipids (Men &gt; 35 yrs old, Women &gt; 45 yrs old)</b>			
Glucose (mg/dL) _____		Total Cholesterol _____ HDL _____ LDL _____	
		Triglycerides _____	

<b>Intestinal Parasite Screening</b>	
Pre-Departure presumptive treatment? Yes <input type="checkbox"/> Albendazole <input type="checkbox"/> Other _____ <input type="checkbox"/> Ivermectin <input type="checkbox"/> No <input type="checkbox"/> Praziquantel <input type="checkbox"/> Unknown	Domestic presumptive treatment? Yes <input type="checkbox"/> Albendazole <input type="checkbox"/> Other _____ <input type="checkbox"/> Ivermectin <input type="checkbox"/> Other _____ <input type="checkbox"/> Praziquantel <input type="checkbox"/> No
Serology test: (see population specific) Strongyloides: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not Done Schistosoma: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not Done	
Stool Test (soil-transmitted helminths and other parasites commonly found in stool) O&P x 1 ___/___/___ (date) <input type="checkbox"/> No parasites found <input type="checkbox"/> Sample not returned O&P x 2 ___/___/___ (date) <input type="checkbox"/> No parasites found <input type="checkbox"/> Sample not returned <input type="checkbox"/> Parasites found (check all that apply below) Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No; why not? _____	
<input type="checkbox"/> Ascaris <input type="checkbox"/> Trichuris <input type="checkbox"/> Strongyloides <input type="checkbox"/> Tapeworm <input type="checkbox"/> Giardia <input type="checkbox"/> Clonorchis <input type="checkbox"/> Entamoeba histolytica <input type="checkbox"/> Whipworm <input type="checkbox"/> Schistosoma <input type="checkbox"/> Hookworm <input type="checkbox"/> Paragonimus <input type="checkbox"/> Other _____	
<b>Malaria Screening</b> See guidelines for presumptive treatment post-arrival	
Pre-Departure presumptive treatment? Yes <input type="checkbox"/> Artemether-Lumefantrine (Coartem) Yes <input type="checkbox"/> Other _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Domestic presumptive treatment? Yes <input type="checkbox"/> Artemether-Lumefantrine (Coartem) Yes <input type="checkbox"/> Other _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Malarial screening? <input type="checkbox"/> Yes, Rapid Diagnostic Test <input type="checkbox"/> Yes, Blood Smear <input type="checkbox"/> No	
Results: <input type="checkbox"/> Positive Species: _____ Treated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Negative	
<b>Referrals: (check all that apply)</b>	
<input type="checkbox"/> Primary Care / Family Practice <input type="checkbox"/> OB/GYN or Family Planning <input type="checkbox"/> WIC <input type="checkbox"/> Pediatrics <input type="checkbox"/> Children with Special Health Care Needs <input type="checkbox"/> Nutrition <input type="checkbox"/> Social Services <input type="checkbox"/> Home Care/PCA <input type="checkbox"/> Orthopedics <input type="checkbox"/> Occupational/Physical Therapy	<input type="checkbox"/> Ear, Nose & Throat (ENT) <input type="checkbox"/> Audiology/Hearing <input type="checkbox"/> Ophthalmology/Optometry <input type="checkbox"/> Dental <input type="checkbox"/> Dermatology <input type="checkbox"/> Mental Health <input type="checkbox"/> Neurology <input type="checkbox"/> Emergency/Urgent Care <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Public Health Nurse (PHN)
<input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiology <input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology (GI) <input type="checkbox"/> Nephrology <input type="checkbox"/> Urology <input type="checkbox"/> Radiology <input type="checkbox"/> Hematology/Oncology <input type="checkbox"/> Immunology/Allergy <input type="checkbox"/> Surgery	
<input type="checkbox"/> Vitamins recommended: <input type="checkbox"/> Multivitamin <input type="checkbox"/> Vitamin D <input type="checkbox"/> Prenatal <input type="checkbox"/> Population specific: <input type="checkbox"/> Bhutanese, B12 <input type="checkbox"/> Other _____	
<b>Additional Labs and Screening</b>	
<input type="checkbox"/> Population specific: Test for Vitamin B12 in Bhutanese with clinical manifestations suggestive of deficiency <input type="checkbox"/> Infant metabolic screening in newborns, according to state guidelines <input type="checkbox"/> In clinic settings allowing for follow up in primary care consider: cancer screening	
<b>Notes</b>	
Provider Signature: _____ / ____ / ____ (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.

<b><i>Disease or Condition Screening Recommendations</i></b>	
<b>Immunizations</b>	<p>Review overseas vaccinations received on DS-3025 overseas exam and ask patient if they have personal copies of vaccinations received overseas. Assess and update immunizations for each individual; immunizations are not needed if immune. If vaccination records are unavailable, an age-appropriate vaccination schedule should be initiated. However, serologic testing for immunity (i.e., antibody testing) is an alternative when the provider believes the patient is likely to have had a previous infection that conveyed immunity or if they received a full series of vaccines that was not recorded. 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.</p>
<b>Lead</b>	<p>Venous blood lead level (BLL) screening is recommended for all children <math>\leq</math> 16years, and individuals who are pregnant or breastfeeding. For those with elevated BLL <math>\geq</math>3.5 <math>\mu</math>g/dL, check for lead sources and check BLLs in all family members. Ensure follow up management. Within 3-6 months after initial testing, a blood lead test should be repeated for all children and adolescents who had BLLs at or above 3.5 <math>\mu</math>g/dL. All infants and children <math>\leq</math>6 years of age, and children 7–16 years of age who have risk factors (e.g., sibling with BLL at or above 3.5 <math>\mu</math>g/dL, environmental exposure risk factors), should receive follow-up blood testing within 3-6 months after initial testing regardless of initial screening result. Prescribe daily pediatric multivitamins with iron for children 6 to 59 months of age.</p>
<b>Tuberculosis (TB)</b>	<p>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.</p> <ul style="list-style-type: none"> <li>• 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-2<sup>nd</sup> trimester, but should still be completed. If pregnant and symptomatic, requires CXR regardless of gestational age.</li> <li>• A chest x-ray should be performed regardless of QTB or TST result for             <ul style="list-style-type: none"> <li>○ those with TB Class A or B1 designation from overseas exam or</li> <li>○ those who have symptoms compatible with active TB disease.</li> </ul> </li> </ul> <p>*IGRAs, unlike the TST, are not affected by prior BCG vaccination and are not expected to give a false-positive result in people who have received BCG.</p>

**Hepatitis B**

Check if the patient was tested for HBsAg overseas. If not, 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 newcomers, regardless of age or vaccine history. If HBsAg is Negative, initiate or complete vaccination series as needed. Test for Hepatitis D in those with a positive HBsAg. Refer all persons with chronic HBV infection for additional ongoing medical evaluation.

	Serologic Marker				Interpretation (I) & Initial Management (M)
	HBsAg	anti-HBc	IgM anti-HBc	anti-HBs	
<b>Test Results</b>	-	-	-	-	<b>I:</b> Never infected and susceptible to infection <b>M:</b> Recommend hepatitis B vaccination series according to ACIP recommendations
	+	+	-	-	<b>I:</b> Chronic HBV infection <b>M:</b> Obtain additional testing including HBV DNA, HBeAg, anti-HBe, and ALT, <b>AND</b> link to care; provide patient counseling related to chronic HBV infection
	-	+	-	+	<b>I:</b> Immune following natural infection <b>M:</b> No additional vaccination needed for HBV, even if series was initiated pre-departure
	+	+	+	-	<b>I:</b> Acute HBV infection <b>M:</b> Refer for clinical assessment if symptomatic, otherwise recheck HBsAg 6 months after initial testing
	-	-	-	+	<b>I:</b> Immune due to hepatitis B vaccination <b>M:</b> No action needed
	-	+	-	-	<b>I:</b> Various interpretations: <ol style="list-style-type: none"> <li>1. Resolved infection (most common in regions with intermediate or high endemicity)</li> <li>2. Chronic infection with low viral load</li> <li>3. Resolving acute infection</li> </ol> <b>M:</b> Obtain additional testing including HBV DNA to rule out occult infection, <b>AND</b> link to care for follow-up and monitoring

**Hepatitis C**

Universal hepatitis C screening should be implemented for all new adult arrivals (≥18 years of age). Testing should consist of anti-HCV and, if positive, HCV RNA testing. Test for HCV in children <18 years with risk factors (HCV-positive mother, injection or intranasal drug use, HIV infection, unaccompanied refugee minor, history of hemodialysis or blood transfusion, signs or symptoms of liver disease, household contacts with HCV, or history of female genital mutilation or cutting). *Because anti-HCV testing in children younger than 18 months may be falsely positive due to detection of passively acquired maternal antibody, testing prior to age 18 months should consist of HCVRNA testing.* Refer all persons with chronic HCV infection for additional ongoing medical evaluation

<p><b>Sexually Transmitted Infections</b></p>	<p><b><u>Pregnancy</u></b>  Urine pregnancy test should be performed for all individuals of childbearing age and pubescent adolescent girls.</p> <p>Refugees are not tested for <b>HIV</b> infection prior to arrival in the United States. Administer routine screening for HIV in 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. In most situations, complete risk factor info is unavailable, and child should be screened. Children &lt;18 months who test positive for HIV antibodies should receive further testing with DNA or RNA assays, as antibody tests can be unreliable at this age, as they may detect persistent maternal antibody. Screening for ages ≥65 is also encouraged.</p> <p><b><u>Syphilis</u></b>  Screening tests should be performed routinely for refugees in the following categories:</p> <ul style="list-style-type: none"> <li>• All refugees aged 18 years to those aged less than 45 years, if no overseas results are available.</li> <li>• Refugees 45 years and older, if there is reason to suspect infection.</li> <li>• Refugees younger than 18 years of age who are at risk for congenital syphilis (i.e., mother who tests positive for syphilis, if the mother's syphilis results are not available, or the child is unaccompanied), who disclose sexual activity, or have been sexually assaulted</li> </ul> <p>Screen for syphilis by administering VDRL or RPR. Positive nontreponemal test results should be confirmed using a treponemal test (e.g., TP-PA, EIAs, ELISAs, or other confirmatory test.</p> <p><b><u>Chlamydia and Gonorrhea</u></b> NAATs are recommended for the following groups:</p> <ul style="list-style-type: none"> <li>• All newcomers aged 18 to 24 years who do not have documented pre-departure testing</li> <li>• All individuals aged less than 18 years or greater than 24 years must be tested if there is a reason to suspect infection, or if there are risk factors, such as a new sex partner or multiple sex partners, sex partner with concurrent partners, or sex partner who has a sexually transmitted infection.</li> <li>• Female newcomers with abnormal vaginal or rectal discharge, intermenstrual vaginal bleeding, or lower abdominal or pelvic pain</li> <li>• Male newcomers with urethral discharge, dysuria, or rectal pain or discharge</li> </ul> <p><b><u>FGM/C</u></b>  Screen women and girls from countries where female genital mutilation/cutting (FGM/C) is practiced for possible FGM/C-associated medical complications, including chronic pain and recurrent urinary tract infections.</p>
<p><b>Mental Health</b></p>	<p>Providers should be aware of the high prevalence of depression, post-traumatic stress disorder (PTSD), panic attacks, adjustment disorders, substance abuse, and somatization in refugees. It is common for refugees to present with stress-related somatic symptoms such as changes in appetite, nightmares, sleeplessness, muscle tension, headaches, stomachaches and back pain. Refugees experiencing these symptoms with unexplained etiology or other mental health symptoms should be referred to a mental health professional.</p>

<p><b>Intestinal Parasites</b></p>	<p><b><u>For All Newcomers:</u></b></p> <p><b>Perform a complete blood count (CBC) with differential.</b> If eosinophil count is elevated (&gt;450 cells/<math>\mu</math>L), re-check in 3-6 months and evaluate further if still elevated. This is the only parasite screening necessary for refugees who have received full pre-departure presumptive treatment.</p> <hr/> <p><b><u>For new arrivals who have lived in the Middle East, Asia, Latin America, the Caribbean, or Africa:</u></b></p> <p><b>Young infants (less than 6 months)</b> without history of direct skin contact with soil (e.g. walking with bare feet) or fecal-oral contact are at low risk of infection and testing is not recommended unless there are signs or symptoms of infection (e.g., elevated absolute eosinophil count).</p> <p><b>If no pre-departure <u>albendazole</u> for soil transmitted <u>helminths</u>:</b></p> <p>(Option 1) Provide presumptive albendazole treatment, unless the individual is a child &lt; 1 year of age, pregnant, or has known neurocysticercosis, evidence of cysticercosis (e.g., subcutaneous nodules), or has a history of unexplained seizures.</p> <p>(Option 2) Conduct stool ova and parasites examination (2 or more samples collected 12 to 24 hours apart).</p> <p><b>If no pre-departure <u>ivermectin</u> for <u>Strongyloidiasis</u>:</b></p> <p>(Option 1) Provide presumptive ivermectin therapy unless the individual is a child &lt; 15 kg or measuring &lt; 90 cm, pregnant or breastfeeding within the first week after birth, or has resided in a loa loa-endemic country in sub-Saharan Africa and has not screened negative for loa loa microfilia.</p> <p>(Option 2) Conduct a Strongyloides IgG serology. Stool ova and parasite testing lacks sensitivity for Strongyloides infection and should not be used to rule out infection.</p> <hr/> <p><b>For all individuals from sub-Saharan Africa:</b></p> <p>Young infants (less than 6 months) without a history of direct skin-to-fresh water contact are at low risk of infection and testing is not recommended unless there are signs or symptoms of infection (e.g., elevated absolute eosinophil count).</p> <p><b>If no pre-departure <u>praziquantel</u> for <u>Schistosomiasis</u>:</b></p> <p>(Option 1) Provide presumptive praziquantel therapy unless the individual is a child &lt; 4 years of age or measuring &lt; 94 cm, or the individual has known neurocysticercosis, evidence of cysticercosis (e.g., subcutaneous nodules), or a history of unexplained seizures.</p> <p>(Option 2) Conduct serologies for Schistosomiasis.</p>
<p><b>Malaria</b></p>	<p>Screen newcomers who present with symptoms suspicious of malaria. For asymptomatic individuals from sub-Saharan Africa, screen or presumptively treat if no documented predeparture therapy and within 3 months of U.S. arrival (note contraindications for pregnant individuals in their first trimester, and children &lt; 5 kg). Diagnostic testing should be performed with blood smears or a rapid diagnostic test.</p>

## **OMRS Best Practices**

CDC recommendations change often. We've compiled a list below that is more resistant to these changes, and that has been reviewed by State Refugee Medical Advisor, Dr. William Frank.

Physician discretion is advised. Clinicians should use their discretion if someone is symptomatic.

### **Everyone Should Receive:**

CBC – with differential

Tuberculosis – QuantiFERON: should be done on everyone unless contraindicated, even if done overseas. Skin testing of limited value and needs two visits

Hepatitis Screening Panel – Regardless of Overseas Testing

Syphilis

HIV

### **General Laboratory Testing**

Chlamydia/Gonorrhea – Everyone of childbearing age, with no age limit on victims of sexual violence.

Pregnancy – should be done in all women of childbearing age, unless they are known to be pregnant.

Glucose and Lipids – anyone over 35 years of age

Lead – Everyone 16 years old and younger, pregnant, and lactating individuals

### **Parasites**

Malaria – Should be done on everyone at risk (by location) unless they have received overseas treatment - thick smear and antigen.

Soil Transmitted Helminth Infections – Should receive Albendazole if not pretreated and over 1 year of age

Strongyloides and Schistosoma Infection – Strongyloides and Schistosomiasis IgG titers on everyone if not pretreated overseas.

**For Questions, Please E-mail [OMRSHealthTeam@CCMaine.org](mailto:OMRSHealthTeam@CCMaine.org)**