STATE OF MARYLAND

DHMH

REFUGEE HEALTH ASSESSMENT FORM

To be completed within 180 days of U.S. arrival or asylum date.

Person completing form: _____
Client's RMA Card present? ☐ Yes ☐ No

Initial Screening Date (mm/dd/yyyy): _____
Final Screening Date (mm/dd/yyyy): _____
Interpreter Needed? ☐ Yes ☐ No **Interpreter Used?** ☐ Yes ☐ No
☐ Telephonic ☐ Bilingual Staff ☐ Contracted ☐ Other

DEMOGRAPHICS

Name (Last, First, Middle)		**Gender** ☐ **Male** ☐ **Female**	**Alien #**	**File #**
DOB (mm/dd/yyyy)	**Age**	**Country of Birth**	**Nationality**	**Name of Refugee Camp**
County of Residence	**Resettlement/Volunteer Agency**	**Agency performing health screen**	**Primary language spoken**	

Ethnicity (Hispanic or Latino)
☐ **Yes** ☐ **No**
☐ **Unknown**

Race (select one or more, if multiracial, 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 Immigrant Visa**

Migration Status ☐ **Primary** ☐ **Secondary (within U.S.)**	**Date of arrival in the U.S. (mm/dd/yyyy)**	**If asylee, date asylum granted (mm/dd/yyyy)**

SCREENING INFORMATION

General Health Screening

Waiver (please list the condition) ☐ Class A _____ ☐ Class B_____ ☐ Class B1 TB ☐ Class B2 TB ☐ Class B3 TB

Medical history reviewed? (√ one) ☐ Yes ☐ No
Pregnancy Test? (√ one) ☐ Negative ☐ Positive ☐ Not applicable ☐ Not evaluated
General physical exam conducted? (√ one) ☐ Yes ☐ No
Date of CBC with differential (mm/dd/yyyy) _____
Hemoglobin _____ g/dL **Hematocrit** _____**%** **Eosinophil count** _____cells/µL

Total Cholesterol _____ mg/dL
HDL Cholesterol _____ mg/dL

Iron _____ µg/dL ☐ Normal ☐ Abnormal ☐ Not applicable ☐ Not evaluated

Urinalysis ☐ Normal ☐ Abnormal ☐ Not evaluated

Comp. Metabolic Panel ☐ Evaluated ☐ Not evaluated

(Values only needed for abnormal test results) (mEq/L is equivalent to mmol/L)

Albumin:	☐ Normal	☐ Abnormal	_____ g/dL	Chloride:	☐ Normal	☐ Abnormal	_____ (mEq/L) or (mmol/L)
Alkaline phosphatase (ALP):	☐ Normal	☐ Abnormal	_____IU/L	Carbon Dioxide:	☐ Normal	☐ Abnormal	_____ (mEq/L) or (mmol/L)
ALT (alanine aminotransferase):	☐ Normal	☐ Abnormal	_____IU/L	Creatinine:	☐ Normal	☐ Abnormal	_____ mg/dL
AST (aspartate aminotransferase):	☐ Normal	☐ Abnormal	_____IU/L	Glucose:	☐ Normal	☐ Abnormal	_____ mg/dL
BUN (blood urea nitrogen):	☐ Normal	☐ Abnormal	_____mg/dL	Potassium:	☐ Normal	☐ Abnormal	_____ (mEq/L) or (mmol/L)
Calcium:	☐ Normal	☐ Abnormal	_____mg/dL	Sodium:	☐ Normal	☐ Abnormal	_____ (mEq/L) or (mmol/L)
				Total bilirubin:	☐ Normal	☐ Abnormal	_____ mg/dL
				Total protein:	☐ Normal	☐ Abnormal	_____ g/dL

For the following, please provide a current assessment (please do not fill in information as abstracted from the overseas record):
Height _____**in.** (list in inches) **Weight** _____ (list in pounds)

Blood Pressure	☐ Normal (for age)	☐ Abnormal	
Vision	☐ Evaluated	☐ Not evaluated	☐ Referred
Hearing	☐ Evaluated	☐ Not evaluated	☐ Referred
Oral Health	☐ Evaluated	☐ Not evaluated	☐ Referred
Multivitamins Provided	☐ Yes	☐ No	☐ Declined

Tuberculosis Screening

Tuberculin Skin Test (√ one)
(give regardless of BCG history)
Result: _____ mm
☐ Patient declined test
☐ Placed, not read
☐ Documented prior positive

Blood Assay for *M. tuberculosis*?
☐ Yes ☐ No ☐ Not applicable
If Yes, which test?
☐ Quantiferon: Result _____IU/mL
☐ T-spot: Result _____spots

Interpretation of QFT or T-spot
☐ Negative ☐ Positive ☐ Indeterminate

Chest X-Ray: (taken in U.S.) (√ one)
Date of X-Ray: _____ (mm/dd/yyyy)
☐ Normal
☐ Abnormal, not consistent with TB
☐ Abnormal, stable, indicative of old TB
☐ Abnormal, cavitary
☐ Abnormal, non-cavitary, consistent with TB
☐ Pending
☐ Patient declined CXR
☐ Not applicable

TB status (√ one)
☐ Active
☐ Suspect
☐ Latent
☐ Old TB
☐ TB not identified

TB Therapy: (√ one)
☐ Treatment for suspected or confirmed active TB
Date Started: _____
☐ Treatment for Latent TB infection (LTBI) prescribed:
Date Started: _____
☐ No TB or LTBI treatment; Reason:
☐ Treatment not indicated
☐ Completed treatment overseas
☐ Pregnancy
☐ Patient declined treatment
☐ Medical condition other than pregnancy
☐ Patient lost in follow-up
☐ Further evaluation pending
☐ Other: _____

Blood Lead Level Screening (Recommended for all children ≤ 16 years of age)

Was blood lead level testing provided? (√ one) ☐ Yes ☐ No ☐ Not applicable
Date of blood draw: _____ (mm/dd/yyyy) **Result:** ____ (µg/dL) **Date of follow-up test:** _____ (mm/dd/yyyy) **Result:** ____ (µg/dL)
If result was ≥ 5 µg/dL, was patient referred? ☐ Yes ☐ No

Immunization Record

Review overseas medical exam (DS-2054) and the Vaccination Documentation Worksheet (DS -3025) if available and document immunization dates. For measles, mumps, rubella, varicella, and HBV: indicate titer results; if immune, immunizations are not needed against that particular disease. For all other immunizations: update series, or begin primary series if no immunization dates are found. Please follow the current Maryland Childhood and Adult Immunization Schedules http://phpa.dhmh.maryland.gov/OIDEOR/IMMUN/.

Titer Tests ☐ Yes ☐ No **☐ Immunization records available & reviewed** **☐ Immunization records not available**

Vaccine-Preventable Disease/ Immunization	Titer Results			Immunization Date(s)					
	Positive	Negative	Equivocal	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
MMR									
Measles	☐	☐	☐						
Mumps	☐	☐	☐						
Rubella	☐	☐	☐						
Varicella (VZV)	☐	☐	☐						
Diphtheria, Tetanus, & Pertussis (DTaP, DTP, Tdap)									
Diphtheria-Tetanus (Td, DT)									
Polio (IPV, OPV)									
Hepatitis B (HBV)	☐	☐	☐						
***Haemophilus influenzae* type b** (Hib)									
Influenza									
Pneumococcal									
Other _____									

Hepatitis B Screening

☐ **Tested for Hepatitis B?** (√ one) ☐ Yes ☐ No ☐ Refused ☐ Evaluated, but testing not required
☐ **Anti-HBs** (√ one) ☐ Negative ☐ Positive (*If positive, patient is immune.)*
☐ **HBsAg** (√ one) ☐ Negative ☐ Positive
☐ **Anti-HBc (total)** ☐ Negative ☐ Positive
☐ **IgM anti-HBc** ☐ Negative ☐ Positive
(If positive HBsAg, patient is infected with HBV and is infectious to contacts; needs HBV counseling and all household contacts must be screened)
If positive HBsAg, were all household contacts screened? ☐ Yes ☐ No
If YES, were all susceptibles started on vaccine? ☐ Yes ☐ No

Sexually Transmitted Infections Screening (√ one for each of the following)

Overseas syphilis screening results reviewed? (only necessary for those ≥ 15 years of age) ☐ Yes ☐ No ☐ Not available
***If positive, syphilis testing must be repeated in the U.S.*

Sexually Transmitted Infections Screening Continued:

Syphilis screening test in U.S. (VDRL/RPR) **Date:** _____ ☐ Negative ☐ Positive ☐ Not applicable ☐ Not Done
Syphilis confirmation test in U.S. (EIA/FTA/TPPA) **Date:** _____ ☐ Negative ☐ Positive ☐ Not applicable ☐ Not Done
If diagnosed with syphilis, was the patient treated? ☐ Yes ☐ No ☐ Referred

Tested for Chlamydia? ☐ Yes (Date: _____) ☐ No **Result:** ☐ Negative ☐ Positive
If positive, was the patient treated? ☐ Yes ☐ No ☐ Referred
Tested for Gonorrhea? ☐ Yes (Date: _____) ☐ No **Result:** ☐ Negative ☐ Positive
If positive, was the patient treated? ☐ Yes ☐ No ☐ Referred
Tested for HIV? ☐ Yes (Date: _____) ☐ No **Result:** ☐ Negative ☐ Positive
If positive, was the patient treated? ☐ Yes ☐ No ☐ Referred

Intestinal Parasite Screening (√ one for each of the following)
Was testing for parasites done? (√ one)
☐ Evaluated, but testing not required
☐ Stool kits offered, but not returned
☐ Tested, results pending
☐ Tested, no parasites found
☐ Tested, parasite(s) found: (√ all that apply)

☐ Ascaris	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred	☐ Schistosoma	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred
☐ Blastocystis	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred	☐ Strongyloides	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred
☐ Clonorchis	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred	☐ Trichuris	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred
☐ E. histolytica	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred	☐ Other _____	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred
☐ Giardia	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred	_____	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred
☐ Hookworm	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred	_____	Treated? ☐ Yes ☐ No	☐ Not required	☐ Referred

Intestinal Parasite Presumptive Treatment (When given overseas, pre-departure presumptive treatment is listed on the Alien Info. coversheet)

	Strongyloidiasis			**Schistosomiasis**			**Soil-transmitted Helminths**		
Documented Pre-departure Presumptive Treatment	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Post-arrival Presumptive Treatment Given	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A

Mental Health Screening (only necessary for those ≥18 years of age)
Mental Health Screening? ☐ Yes (Date: _____) ☐ No ☐ Not applicable ☐ Declined (provide reason in Mental Health Comments)
(If NO, check appropriate reason) ☐ Has cognitive impairment ☐ Has diagnosed mental health condition
☐ Has hearing impairment ☐ Other (please specify) _____

Person administering Mental Health Screening: _____ Name of Interpreter for RHS-15: _____

Symptoms Total Score (Items 1-14 from RHS-15) _____
Distress Thermometer Score (Item 15 from RHS-15) _____ **Patient educated on score?** ☐ Yes ☐ No
Needs Referral? ☐ Yes ☐ No
Referral Accepted? ☐ Yes ☐ No
(If NO, check appropriate reason) ☐ Patient doesn't believe services are needed ☐ Patient did not specify reason
☐ Patient wants to keep problems private ☐ Other (please specify) _____
☐ Patient is planning to move

Referral due to: (√ all that apply) ☐ Score ☐ Overseas Diagnosis ☐ Observation ☐ Crisis
If crisis condition, was patient referred during visit? ☐ Yes ☐ No
Crisis Referral made to whom: _____

Any mental health conditions identified in overseas documentation? ☐ Yes ☐ No ☐ Not Available
(If YES, please provide details in Mental Health Comments section.)
Mental Health Comments: _____

Referrals Provided (√ all that apply)

☐ Primary Care Provider	☐ Dental	☐ Vision	☐ WIC	☐ Neurology	☐ Mental Health	☐ Hearing	☐ Endocrinology
☐ Family Planning	☐ GI	☐ Urology	☐ OB/GYN	☐ Dermatology	☐ Pediatrics	☐ General Medicine	☐ Other Referral