STATE OF MARYLAND

DHMH

Tarehe ya Kwanza ya Uchunguzi (mm/ss/mmmm)/ Initial Screening Date (mm/dd/yyyy): _____
Tarehe ya Mwisho ya Uchunguzi (mm/ss/mmmm)/ Final Screening Date (mm/dd/yyyy): _____

MUHTASARI WA UTATHMINI WA AFYA YA WAKIMBIZI

Refugee Health Assessment Summary- Swahili

DEMOGRAPHICS

Jina (Mwisho, Kwanza, Katikati) Name (Last, First, Middle):		**Jinsia** (Gender): ☐ **Mwanamume** (Male) ☐ **Mwanamke** (Female)		**Namba ya Ugeni** (Alien #):
Tarehe ya Kuzaliwa (mm/ss/mmmm) (DOB (mm/dd/yyyy)):	**Anwani** (Address):	**Jina na Namba a Simu ya Mfadhili** (Sponsor Name and Phone #):		**Jina na Namba ya Simu ya Meneja wa Kesi** (Case Manager Name & Phone #):
Chombo cha Uchunguzi wa Afya (Health Screening Agency):	**Chombo cha Makazi/Kujitolea** (Resettlement Agency):	**Tarehe ya Kuwasili Kufika** (Date of Arrival in US):	**Nchi ya Kuzaliwa** (County of Birth):	**Daktari/Muuguzi wa Uchunguzi** (Screening Physician/Nurse):

MAPATO YA UTATHMINI / ASSESSMENT FINDINGS

Utambuzi: ☐ **Utathmini wa Uchunguzi wa Afya ya Wakimbizi umekamilishwa** Refugee Health Assessment completed ☐ **Kipimo kisicho cha kawaida au mapato ya historia ya matibabu** *Abnormal exam or medical history findings (see Notes below)* ☐**Ujauzito** Pregnancy

☐ **Kinyesi/Serelojia ilipimwa na kuonekana kuwa na ovariri au vidudu** Stool/Serology tested positive for ova or parasites ☐ **Matibabu ya Kifua kikuu Fiche** Latent Tuberculosis Treatment ☐ **Kifua kikuu** Tuberculosis ☐**Nyingine** _____ Other

Vipimo vya maabara vilivyoagizwa(Labs Ordered): ☐ **Kinyesi kwa O&P** Stool for O&P ☐ **Mate** Sputum ☐ **Eksirei ya Kifua** Chest X-Ray ☐ **Michanganyiko** Immunization Titers ☐ **Hesabu Kamili ya Damu (CBC)** Complete Blood Count

☐ **Kiwango cha Risasi katika Damu** Blood Lead Level ☐ **Kipimo cha Utendaji kazi wa Ini (LFT)** Liver Function Test(LFT) ☐ **Kipimo cha UKIMWI** HIV Test ☐ **Ugonjwa Antijeni wa Ini** Hepatitis B Antigen ☐ **Kaswende (RPR)** Syphilis ☐ **Kisonono/Klamidia** Gonorrhea/Chlamydia

Matokeo ya Maabara (Angalia Fomu ya Utathmini wa Afya): *Lab Results* *See Health Assessment Form* **Fomu ya Utathmini wa Afya Imeambatishwa:** *Health Assessment Form Attached?* ☐ **Ndiyo** *Yes* ☐ **Hapana** *No*

Chanjo iliyopewa (Immunizations administered)**:** ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ DTaP/Tdap/Td ☐ Influenza ☐ Twinrix (Hep A & B) ☐ **Nyingine** _____ (Other)

Michanganyiko ya chanjo—Kinga ya (Immunization Titers—Immune to): ☐ **Ukambi** (Measles) ☐ **Machubwichumbwi** (Mumps) ☐ Rubela ☐ Varicella ☐ Hepatitis B ☐ Hepatitis C

MAREJELEO / REFERRALS

Unaelekezwa kwa (You have been referred to): ☐ **Mtoa Huduma Msingi kwa huduma zaidi ya matibabu** *Primary Care Provider for further medical care* ☐ **Daktari wa Meno** *Dentist*

☐ **WIC/Mtaalamu wa Lishe** (WIC/Nutritionist) ☐ **Daktari wa macho** (Optometrist) ☐OB/GYN

☐ **Mpango wa LHD TB kwa utathmini zaidi/kuanza kutumia dawa (LHD/kituo kingine cha marejeleo**: _____)
(LHD TB Program for further evaluation/start medication (LHD/other referral center: _____))

☐ **Mtaalamu wa** _____ (Specialist for) ☐ **Mwingine**_____ (Other) ☐ **Hakuna** (none)

Utahitaji miadi ya kufuatilia katikati ya _____ **kwa** _____.
(bainisha muda) (bainisha lengo)

You will need a follow-up appointment within _____ for _____.
(specify timeframe) (specify purpose)

DAWA/ MEDICATIONS

Uliagiziwa dawa? (Medications prescribed?) ☐ **Ndiyo** (Yes) ☐ **Hapana** (No)

Tafadhali orodhesha majina ya dawa na sababu ya kuagizwa*: (Please list names of medications and reason prescribed:)*

_____

Dawa zimekaguliwa dhidi ya fomyula ya MCO? (Medications checked against MCO formulary?) ☐ **Ndiyo** (Yes) ☐ **Hapana** (No)

HATUA ZINAZOFUATA/ NEXT STEPS

☐ **Piga simu kwa nambari iliyo kwenye kadi yako ya bima ili kupanga miadi na daktari wako**.
Call the number on your insurance card to schedule an appointment with your doctor.

☐ **Miadi yako inayofuata iko**_____ (**tarehe/saa**) **kwa** _____ (**lengo**).
Your next appointment is on _____ (date/time) for _____ (purpose).

☐ **Piga simu kwa** _____ **kama una maswali au hoja zozote kahusu utathmini wako wa afya ya wakimbimizi**.
Call _____ if you have any questions or concerns about your refugee health assessment.

☐ **Tumia dawa kama ulivyoagizwa**.
Take medication as directed

☐ **Pendeleza kipimo cha ufuatiliaji vijidudu vya kinyesi kulingana na maelekezo ya CDC**:
http://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-domestic.pdf
Recommend stool parasite follow-up per CDC guidelines: http://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-domestic.pdf.

☐ **Mpe nakala ya fomu hii kwa daktari au muuguzi wako.**
Give a copy of this form to your doctor or nurse.

VITINI/ NOTES

_____

_____

_____ _____ _____

Jina la mtu anayekamilisha fomu hii
Name of person completing the form

Sahihi ya mtu anayekamilisha fomu hii
Signature of person completing the form

Tarehe
Date