



'ku@onf usef;rma;&pdppfcsuf tusOf;csLyf

REFUGEE HEALTH ASSESSMENT SUMMARY- BURMESE

udk,fa;&tcsuftvufsrsm/ DEMOGRAPHICS

trn f (tqHk;?tv,f?tp) Name (Last, First, Middle):		Vdlf (Gender) <input type="checkbox"/> usm; (Male) <input type="checkbox"/> r (Female)		tjcm;EdkifHom; # (Alien)
arg;aeY (v?aeY?ESpf) (DOB (mm/dd/yyyy))	Vdyfpm (Address)	uruxyKol trmfESifzhk; # (Sponsor Name & Phone #)		auhpfrefae*sm trmfESifzhk; Case Manager Name & F
usef;rma;&ppfaq;&mXme Health Screening Agency	ae&mcsxm;a;&?apwemhOefxrf; Xme Resettlement/Volunteer Agency	tar&duefjynfaxm;lfpkodkYa&muf&SdaomaeYpGJ Date of Arrival in the U.S.	arG;zGm;&mEdkifH Country of Birth	Pppfaq;aomq&mOef? olem Screening Physician/NU

ppfaq;awGY&Sdcsufsrsm/ ASSESSMENT FINDINGS

pdppfcsuf- (Diagnosis) 'ku@onfusef;rma;&ppfaq;rSKNyD;pD; (Refugee Health Assessment completed) rlrSefaoamppfaq;rSK odkYr[kwfaemufaMumif; awGY&Sdcsufsrsm; (atmuf&SdrSwfcsufwGif&SK) exam or medical history findings)

udk,fOef (Pregnancy) Orf;?q,f&r ppfaq;&mwGif tdkAm odkYr[kwfydk;rTm;&SdaMumif;awGY&Sd (Stool/Serology tested positive for ova or parasites) wDbD (Tuberculosis)

tvn;tvm&SdwDbDukorSK (Latent Tuberculosis Treatment) tjcm; _____ (Other)

"mwfcGjppfaq;rSKrsm;- (Labs ordered) tdkESifhyDtwGuf Orf; (Stool for O&P) ovdyf (Sputum) ifbwf "mwfrSef (Chest X-Ray) a&m*gcHEdkif&nfawwmsm; (Immunization titers)

aoG;wdkif;wmrSK (pDbDpD) (Complete Blood Count) aoG;wGifcJygOifrSK (Blood Lead Level) tonf;ppfaq;rSK (t,fvftufzfwD) (Liver Function Test) tdwfcstdkifAD ppfaq;rSK (HIV Test)

tonf;a&mifom;Og bD tifwD*sif (Hepatitis B Antigen) qpzvpf (tm&fyDtm&f) (Syphilis) *Edk&D;,m;? csvrfrD;'D;,m; (Gonorrhea/Chlamydia)

"mwfcGjcef;awGY&Sdcsufsrsm; (usef;rma;&pdppfcsufyHkpH&SK)- Lab Results (see Health Assessment Form):

usef;rma;&pdppfcsufyHkpHyl;wGjCif; &Sd?r&Sd? (Health Assessment Form Attached?) &Sd (Yes) r&Sd (No)

udk;ay;aomumuG,faq;rsm;- (Immunizations Administered): trfrftrm&f (MMR) A,f&Dq,fvm (Varicella) tonf;a&mifom;Og bD (Hepatitis B)

'DwDatyD? wD'DatyD?wD'D (DTaP/Tdap/Td wkyfauG; (Influenza) ESpfxyfuGrf; (tom;Og atESifhbD) (TwinRic (Hep A & B) tjcm; _____ (Other: _____)

umuG,faq;awwmsm;- atmufygdwkYudkumuG,f&ef- (Immunization Titers—Immune to:) qHkqdkYem (Measles) MuufnSm (Mumps)

&lb,fvm (Rubella) A,f&Dq,fvm (Varicella) tonf;a&mifom;Og bD (Hepatitis B) tonf;a&mifom;Og pD (Hepatitis C)

&nfnTef;csufsrsm/ REFERRALS

oifhtn;a&SYazmfjygtwdkif;jyo&ef&nfnTef;vdkufonf- (You have been referred to:)

tajccHukorSKay;oIESifh usef;rma;&jjYkprSKqufvufch,I&ef (Primary Care Provider for further medical care) oGm;ukool (Dentist)

'bvltDkifpD?tm[m&uRrf;usifol (WIC/Nutritionist) rsufpDppfaq;oI (Optometrist) om;zGm;?rD;,yf (OB/GYN)

t,fvftdwfcf'D wDbD tpDtpOfESifh qufvufpDppf&ef? pwifukorSKch,I&ef (t,fvftdwfcf'D ?tjcm; &nfnTef;&mXme- _____)

(LHD TB Program for further evaluation/start medication (LHD/other referral center: _____)

tdl;uk _____ (Specialist for: _____) tjcm; _____ (Other: _____) r&Sd (None)

oifonf a&SYazmfjygy&ufydkif;twGif; qufvufyjo&mf _____ jyo&mfha&m*g _____

(&ufowfrSwf&ef) _____ (udpöowfrSwf&ef)

You will need a follow-up appointment within _____ for _____.

(specify timeframe) (specify purpose)

aq;Og;ukocsufsrsm/ MEDICATIONS

uko&efaq;Og;owfrSwfSK&Sd?r&Sd? (Medications prescribed?) &Sd (Yes) r&Sd (No)

owfrSwfaoemukorSKrsm;ESifhtaMumif;&if;ufidk aus;Zl;jyKiazmfjygy- (Please list names of medications and reason prescribed):

aq;mfowfrSwfcsufsrsm;ESifhaq;ukorSKwdkufqdkifppfaq;jcif;&Sd?r&Sd? (Medications checked against MCO formulary?) &Sd (Yes) r&Sd (No)

qufvufaqmif&GufzG,frsm/ NEXT STEPS

oifhtmrchuwfyg eHywufudkqufoG,fNyD; q&mOefESifh&ufcsdef;,lyg/ (Call the number on your insurance card to schedule an appointment with your doctor.)

oifaemufwpfBudrfjy&mfhaeYonf _____ (aeY?tcsdef) jyo&ef _____ (udpö)/ (Your next appointment is on _____ (date/time) for _____ (purpose).)

a&SYazmfjygzHk; _____ udkqufyg tu,fi oifhwGif 'ku@onfusef;rma;&ppfaq;rSKtaMumif; &Sdygu/ (Call _____ if you have any questions or concerns about your refugee health assessment.)

aq;Og;udk nTefMum;onfhtwdkif;aomufyG/ (Take medication as directed.)

Orf;wGifawGY&aomydk;ESifhywoufi qufvufvfyfaqmif&ef pD'DpDvrf;nTefcsufsrsm;zwf&SK&e (Recommend stool parasite follow-up per CDC guidelines: <http://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-domestic.pdf>.)

oifholemJyKtm;byHkpHrdwÄLwpfapmifay;yg/ (Give a copy of this form to your doctor or nurse.)

rSwfcsufsrsm/ NOTES

yHkpHjznfholtrnf
Name of person completing the form

yHkpHjznfholvufvrSwf
Signature of person completing the form

aeYpGJ
Date