IOWA INITIAL REFUGEE HEALTH ASSESSMENT FORM

Return completed form, preferably within 30 days of U.S. date of arrival, to address on reverse side of this form.

Name (Last, First, Middle):_____ **Arrival Status:** _____
Date of Birth (Month, Day, Year):_____ **Gender:** _____
Alien or Visa Registration #: _____ **Volag:** _____
U.S. Arrival Date (Month, Day, Year):_____ **Country of Origin:** _____
TB Class A or B Status: _____
Date of First Clinic Visit for Screening (month, day, year): _____/_____/_____

Immunization Record: Review overseas medical exam if available and document immunization dates. Indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease. For all other immunizations: update series, or begin primary series if no immunization dates are found.

Vaccine-Preventable Disease/ Immunization	If titers done, check "Y" if immune, "N" if not immune, "I" if indeterminate	Immunization Date(s) OR ☐ *Overseas immunizations done*					
		Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Measles	☐ Y ☐ N ☐ I						
Mumps	☐ Y ☐ N ☐ I						
Rubella	☐ Y ☐ N ☐ I						
Varicella (VZV)	☐ Y ☐ N ☐ I						
Zoster (shingles)							
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)	☐ Y ☐ N ☐ I						
Diphtheria-Tetanus (Td, Tdap)	☐ Y ☐ N ☐ I						
Polio (IPV, OPV)	☐1 ☐2 ☐3 ☐N						
Hepatitis B (HBV)	☐ Y ☐ N ☐ I						
Human Papilloma Virus (HPV)							
Meningococcal conjugate (MCV)							
***Haemophilus influenzae* type b** (Hib)							
Hepatitis A	☐ Y ☐ N ☐ I						
Influenza							
Pneumococcal							
BCG ☐ Yes-Date(s)_____ ☐ No ☐Unknown							

Tuberculosis Screening:

Tuberculin Skin Test (TST)
(regardless of BCG history)
____ mm Induration (not redness)
- ❑ Past history of positive TST (66)
- ❑ Given, not read (77)
- ❑ Declined test (88)
- ❑ Not done (99)

IGRA Test: ☐ **QFT or QFT-GIT** ☐ **Tspot**
- ❑ Positive
- ❑ Negative
- ❑ Indeterminate
- ❑ Not done

Chest X-Ray – done in U.S.
(If TST or QFT positive, Class B, or symptomatic)
- ❑ Normal
- ❑ Abnormal, stable, old or healed TB
- ❑ Abnormal, cavitary
- ❑ Abnormal, non-cavitary, consistent with active TB
- ❑ Abnormal, not consistent with active TB
- ❑ Pending
- ❑ Declined CXR
- ❑ Not done

Diagnosis
(must check one)
- ❑ No TB infection or disease
- ❑ Latent TB Infection (LTBI)*
- ❑ Old, healed not prev. Tx TB*
- ❑ Old, healed prev. Tx TB
- ❑ Active TB disease – (suspected or confirmed)*
- ❑ Pending
- ❑ Incomplete eval., lost to F/U

*Complete TB treatment section

Treatment
(for TB disease or LTBI)
Start Date: ___/____/____
or Reason for not treating
- ❑ Completed Tx overseas
- ❑ Declined treatment
- ❑ Medically contraindicated
- ❑ Moved out of IA
- ❑ Lost to follow-up
- ❑ Further eval. pending
- ❑ Other: _____

TB treatment follow-up clinic if not the same as screening clinic:

Hepatitis B Screening:

1. **Anti-HBs** (✓ one) ☐Negative ☐Positive; *Note if positive, patient is immune.* ☐ Indeterminate ☐Results pending ☐Not done
2. **HBsAg** (✓ one) ☐Negative ☐Positive* ☐Indeterminate ☐Results pending ☐ Not done
   **Note: if positive HBsAg, patient is infected with HBV and infectious to contacts. It is especially important to screen all household contacts.*
   If positive HBsAg, were all household contacts screened? ☐ Yes → were all susceptibles started on vaccine? ___Yes ___No
   ☐ Contacts not screened → why not? _____
3. **Anti-HBc** (✓ one) ☐ Negative ☐ Positive ☐ Indeterminate ☐ Results pending ☐ Not done

Sexually Transmitted Infections: (check one for each of the following)

1. **Syphilis** ☐ Negative ☐ Positive; treated: ___Yes ___No ☐ Pending ☐ Not done; **Syphilis CONFIRM** ☐ Negative ☐ Positive
2. **Gonorrhea** ☐ Negative ☐ Positive; treated: ___Yes ___No ☐ Pending ☐ Not done
3. **Chlamydia** ☐ Negative ☐ Positive; treated: ___Yes ___No ☐ Pending ☐ Not done
4. **HIV** ☐ Negative ☐ Positive; treated: ___Yes ___No ☐ Pending ☐ Not done; **HIV CONFIRM** ☐ Negative ☐ Positive
5. **Other, specify**: _____ ☐ Negative ☐ Positive; treated? ___Yes ___No ☐ Pending

PLEASE TURN THE PAGE FOR MORE TESTS

Complete Blood Count:

1. **CBC with differential done?** ☐Yes ☐ No
   If yes, was Eosinophilia present? ☐ Yes ☐ No ☐ Results pending
   If yes, was further evaluation done? ☐ Yes ☐ No

Intestinal Parasite Screening:

1. **Was screening for parasites done?** ☐ Yes ☐ No If **No,** why not? _____
2. **Serology Test** ☐ Done ☐ Results Pending ☐ Not done
   Schistosoma ☐ Negative ☐ Positive; treated: ___Yes ___No ☐ Indeterminate ☐ Results Pending ☐ Not done
   Strongyloides ☐ Negative ☐ Positive; treated: ___Yes ___No ☐ Indeterminate ☐ Results Pending ☐ Not done
3. **Stool Test** ☐ No parasites found ☐ Results Pending ☐ Not done
   ☐ Non-pathogenic parasites found ☐ Blastocystis; Treated: ___Yes ___No
   ☐ Pathogenic parasite(s) found (*If positive for pathogenic parasite(s) by O&P, check all that apply*)

☐ **Schistosoma** Treated? ☐ Yes ☐ No Species: _____ ☐ **Giardia** Treated? ☐ Yes ☐ No ☐ **Trichuris** Treated? ☐ Yes ☐ No ☐ **Hookworm** Treated? ☐ Yes ☐ No	☐ **Strongyloides** Treated? ☐ Yes ☐ No ☐ **Entamoeba histolytica** Treated? ☐ Yes ☐ No ☐ **Hymenolepis** Treated? ☐ Yes ☐ No ☐ **Paragonimus** Treated? ☐ Yes ☐ No	☐ **Ascaris** Treated? ☐ Yes ☐ No ☐ **Dientameoba** Treated? ☐ Yes ☐ No ☐ **Clonorchis** Treated? ☐ Yes ☐ No ☐ **Other,** (specify): Treated? ☐ Yes ☐ No _____
If not treated, why not?		

Malaria Screening: (check one)

☐ Not screened for malaria (e.g., No symptoms and history not suspicious of malaria) ☐ Screened, no malaria species found in blood smears
☐ Screened, malaria species found (please specify): _____ ☐ Screened, results pending
If malaria species found: Treated? ☐ Yes ☐ No → Referred for malaria treatment? ☐ Yes ☐ No
If referred for malaria treatment, specify physician/clinic: _____

Please fill in for all refugees:

HEIGHT (in)	WEIGHT (lbs)	HEAD CIRCUM. (< 3 yrs old, cm)	PULSE	BP- SYS/DIAS
BLOOD GLUCOSE (mg/dL)	HEMOGLOBIN	HEMATOCRIT %	VIT. B12 (pg/ml)	LEAD (<17 yrs old)

Currently Pregnant ☐ Yes ☐ No ☐ Not done
Mental Health Concern ☐ Yes ☐ No ☐ Not done
Vision Loss ☐ Yes ☐ No ☐ Not done
Hearing Problems ☐ Yes ☐ No ☐ Not done
Dental Problems ☐ Yes ☐ No ☐ Not done
Additional Health Concern? (*list*)_____

Referrals: (check all that apply)

☐ Primary Care / Family Practice	☐ Dentistry	☐ Ophthalmology/Optometry	☐ Audiology/Hearing
☐ Cardiology	☐ Hematology/Oncology	☐ Neurology	☐ Radiology
☐ Dermatology	☐ Immunology/Allergy	☐ Nutrition	☐ Surgery
☐ Ear, Nose & Throat (ENT)	☐ Infectious Disease	☐ Pediatrics	☐ Urology
☐ Emergency/Urgent Care	☐ Internal Medicine	☐ Public Health Nurse (PHN)	☐ WIC
☐ Endocrinology	☐ Mental Health	☐ OB/GYN or Family Planning	☐ Social Services
☐ Gastroenterology (GI)	☐ Nephrology	☐ Orthopedics	☐ Other Referral _____

Interpreter needed: ☐ Yes, language(s) needed: _____ ☐ No

Note: Fill out the Iowa Refugee Health Assessment Form indicating the results of the tests listed on this form and return to the Refugee Health Program within 30 days of receipt. For more information, contact the Refugee Health Program, Iowa Department of Public Health at: (515) 281-0433.

Screening Clinic: _____ **Physician/PA/NP (Last, First):** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **Fax:** (_____)_____

Name/title person completing form: _____ **Date screening completed**: _____/_____/_____

Iowa Department of Public Health
Initial Refugee Health Assessment Form
Recommendations for Refugee / Immigrants

Disease or Condition	Screening Recommendations
Immunization	Assess and update immunizations for each individual. ACIP recommends vaccines for certain age ranges in the general U.S. public. The ACIP recommendations determine which vaccines are age-appropriate for the general immigrant/refugee population.
Tuberculosis (TB)	Perform a **tuberculin skin test (TST) or *blood interferon gamma release assay (IGRA)** for TB for all individuals regardless of BCG history, unless documented previous positive test. Pregnancy is not a medical contraindication for TST testing or for treatment of active or latent TB. TST administered prior to 6 months of age may yield false negative results. o A chest x-ray should be performed for all individuals with a positive TST or IGRA test o A chest x-ray should also be performed <u>regardless of TST results</u> for: o those with a TB Class A or B_1 designation from overseas exam **or** o those who have symptoms compatible with TB disease. *CDC Recommends IGRA's be used in place of the TST for testing persons who have received BCG vaccine, because it increases the diagnostic specificity and the patient is more accepting for treatment of latent TB[1]. QuantiFERON-TB Gold In-Tube (QFT-GIT)® is a blood test manufactured by Cellestis[2] that measures and compares the amount of interferon-gamma (IFN-γ) released in blood cells in response to three TB antigens. The QFT-GIT® assay was FDA approved in 2007. When compared to the TST, the benefits of QFT-GIT® assay are that it only requires a single patient visit to conduct the test, it does not boost responses measured by subsequent tests & prior BCG vaccination does not cause a false-positive IGRA test result. Therefore, fewer individuals need to be referred for further diagnostic testing such as a chest x-ray. A courier system is in place to transport specimens. The CPT code is 86480 and is reimbursable through Medicaid ($88.83). Additional information regarding specimen collection and shipping instructions for the State Hygienic Laboratory can be found in the Tuberculosis tab of the Quick Reference Guide for the Initial Domestic Refugee Health Assessment. [1] Morbidity and Mortality Weekly Report. Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection – United States, 2010. June 25, 2010 / Vol. 59 / No. RR—5 / Pg. 1 – 26. [2] http://www.cellestis.com/IRM/Content/usa/qtfproducts_tbgoldintube.html
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.
Intestinal Parasites	For all refugees arrivals (asymptomatic and symptomatic): o Confirm pre-departure presumptive treatment o Evaluate for eosinophilia by obtaining a **CBC with differential** (eosinophilia>400 cells/ul) o Strongyloides serology (Asians and sub-Saharan Africans / endemic areas) If **<u>no documented</u>** pre-departure presumptive treatment: o Conduct stool examination for ova and parasites (O&P); two stool specimens should be obtained more than 24 hours apart o Eosinophilia requires additional schistosoma serology for sub-Saharan Africans If **<u>documented</u>** pre-departure presumptive treatment: o Eosinophilia with single-dose pre-departure treatment requires additional schistosoma serology for sub-Saharan Africans or presumptive domestic treatment o Eosinophilia with high dose pre-departure treatment requires either O&P or repeat eosinophil count in 3 – 6 months after arrival

Sexual Transmitted Infections

Provide universal syphilis testing for arrivals from areas of the world with high prevalence of HIV/AIDS. (For persons with a documented negative test in the past 6 months and no sexual risk history during that time, report result and date of previously documented test.) Screen for syphilis by administering **VDRL or RPR**. Confirm positive VDRL or RPR by FTA-ABS or TP-PA 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. Use your clinical judgment to screen for chlamydia and gonorrhea using **urine specimen,** if possible. Screen other STIs if indicated by self-report or endemicity in homeland.

HIV

Beginning January 4th, 2010, refugees are no longer tested for HIV-infection prior to arrival in the U.S.

- Current CDC guidelines for the United States recommend HIV screening in health-care settings for all persons 13-64 years of age. Screening of all refugees 13-64 years of age is recommended in accordance with this policy. Screening of all refugees on arrival, including those ≤12 years and ≥64 years of age, is also encouraged.
- Repeat screening 3-6 months following resettlement is recommended for refugees with a recent exposure or high-risk activity to identify individuals who may be in the ―window period‖ when they arrive in the United States. Subsequent screening should be done in accordance with CDC guidelines.
- Screening should be performed on all refugees unless they decline (opt out). Refugees should be clearly informed orally or in writing that HIV testing will be performed. Oral or written information should include an explanation of HIV infection and the meanings of positive and negative test results, and the patient should be offered an opportunity to ask questions. With such notification, consent for HIV screening should be incorporated into the patient's general informed consent for medical care on the same basis as other screening or diagnostic tests.

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 pre-departure 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).

For more information contact:
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Iowa Department of Public Health
321 East 12th Street
Lucas State Office Building
Des Moines, IA 50319-0075
(515) 281-0433
(515) 281-4570 (fax)
http://www.idph.state.ia.us/ImmTb/RefugeeHealth.aspx
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