

Iowa Refugee Program Initial Health Assessment Form

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Patient Information										
Name (last, first, middle):				County:						
Street Address:				City:			State:	Zip:		
Gender:	Date of Birth	(month, day, yea	r):		lowa	a Resettlemen	t Agency:			
Alien or Visa Re	gistration No:			Country of Origin:						
U.S. Arrival Date (month, day, year):			Date of First Clinic Visit for Screening (month, day, year):							
TB Class Status (From overseas medical exam): A B None Unknown										
Immunizatio	on Record									
Review overseas							nmunizations: ι	pdate series, or	begin	
primary series if no immunization		Check box if	Overseas Immunizations done Immunization Date(s)							
Vaccine- Preventable Disease/Immunization		there is evidence of immunity. No immunization needed	Mo/Day/Yr	Mo/Day	//Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	
Measles										
Mumps										
Rubella						_				
Varicella (VZV)						_				
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT) Diphtheria Tetanus (Td) / Tdap*										
Polio (IPV, OPV)										
Hepatitis B (Hep B)		Ш								
Haemophilus influenzae type b (Hib)										
Hepatitis A (Hep A)										
Influenza										
Pneumococcal										
Human Papillomavirus (HPV)										
Meningococcal conjugate (MCV)										
Rotavirus										
Zoster (shingles)										

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^{*}Tetanus, diphtheria and acellular pertussis (Tdap) vaccine can satisfy the Td booster requirement.

Tuberculosis Record					
Tuberculin Skin Test (TST) - Given regardless of history of BCG					
mm induration (not redness)	ed test				
IGRA Test: ☐ QFT-GIT® ☐ T-SPOT® IGRA Result: ☐ F	Positive Negative Indeterminate				
Chest x-ray: (taken in U.S.) Needed if TST or IGRA positive, Class A or B, or symptomatic					
☐ Normal	☐ Abnormal – consistent w/TB				
☐ Non-TB Abnormality	☐ TB- non-cavitary				
☐ Stable, old or healed TB	☐ TB- cavitary				
☐ Pending	☐ Evidence of military TB				
☐ Not done, explain:					
TB Therapy: (if indicated) (check one)					
☐ Treatment for suspected or confirmed active TB(Please call TB Control	I 515-281-8636 or 281-7504) Date started:				
☐ Treatment for latent TB infection (LTBI) prescribed Date started:					
□ No LTBI treatment; Reason:					
☐ Documented treatment overseas for active TB disease completed					
☐ LTBI ruled out					
Refused					
☐ Other:					
Oral Health					
Check all that apply					
☐ Screening not done					
☐ Untreated caries					
☐ Early Childhood Caries					
☐ No natural teeth					
☐ Sealants present					
☐ Periodontal disease risk factors					
☐ Signs of inflammation present					
Treatment urgency: Urgent Early No obvious problem	☐ Prevention				

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Hepatitis B Screening						
Anti-HBs (check only one)	Negative Positive; Note: if positive, patient is immune Results pending					
HbsAg (check only one)	Negative					
*Note: If positive, patient is infected	ed with HBV and infectious to contacts, and it is especially important to screen all household contacts.					
If positive HbsAg, were all househ	old contacts screened?					
If Yes, were all susceptibles starte	If Yes, were all susceptibles started on vaccine?					
Referred for follow-up?	Referred for follow-up?					
Anti-HBc (check only one)						
IgM anti-HBc (check only one)	IgM anti-HBc (check only one) ☐ Negative ☐ Positive* ☐ Results pending ☐ Not done					
*Note: If positive, patient has acu	e HBV infection.					
If positive IgM and anti-HBC was p	patient referred for follow-up?					
Sexually Transmitted Diseases						
HIV* Negative (EIA or rap	HIV* Negative (EIA or rapid) Confirmed Positive (WB) Indeterminate Testing Not done (see below)					
If positive, referred to a specialist?						
Syphilis:	Syphilis:					
Screening tests (VDRL/RPR)	Screening tests (VDRL/RPR)					
☐ Not done, why?						
Confirmation test (FTA-ABS/TP-PA) Negative Positive						
Treatment :						
□ Not done, why?						
Gonorrhea: Negative	Positive Results pending Not done, why?					
	If positive, was the patient treated?					
Chlamydia: Negative	Positive Results pending Not done, why?					
	If positive, was the patient treated?					
Other, specify:	☐ Negative ☐ Positive ☐ Results pending					
	If positive, was the patient treated?					

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Intestinal Parasite Screening						
Was screening for parasites done?						
Serology Test: Positive Stool Test: Pathogenic parasites found						
☐ Nega	tive	☐ No	☐ Non-pathogenic parasites found ☐ Blastocystis			
☐ Indeterminate ☐ No parasites found						
Results Pending Results Pending						
☐ Not done ☐ Not done						
*If positive for pathogenic p	arasite(s), check all th	at apply:				
☐ Ascaris	Treated?	s □ No	Hookworm	Treated?		
Clonorchis	Treated?	s □ No	☐ Schistosoma	Treated?		
☐ Cryptosporidium	Treated?	i □ No	☐ Strongyloides	Treated? Yes No		
☐ Cyclospora	Treated?	s □ No	☐ Trichinella	Treated?		
☐ Entomaeba histolytica	Treated?	s □ No	☐ Trichuris	Treated? Yes No		
Giardia	Treated?	i □ No	Other Specify:	Treated?		
Parasites not treated,	Parasites not treated, why:					
Blood Work						
CBC with differential done? No						
Was Eosinophilia present? ☐ Yes ☐ No ☐ Results pending						
If yes, was further evaluation done? ☐ Yes ☐ No						
Hemoglobin Results: Not done Hematocrit Results: Not done						
ALT: AST: Other:						
Lead screening: (check only one) ☐ Yes; Results: ☐ Not done ☐ N/A						
Currently pregnant: (check only one) Yes; expected date of delivery No Not tested						
Malaria Screening: (check only one)						
Screened, no malaria species in blood smears found						
If malaria species found: Treated? ☐ Yes ☐ No Referred for malaria treatment? ☐ Yes ☐ No						
☐ Ovale ☐ Falciparum ☐ Vivax ☐ Malariae ☐ Not identified						
If referred for malaria treatment, specify						
physician/clinic:						

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Significant information from patient history:				
Significant information from physical exam:				
Communicable Disease Reporting:				
Referrals: (check all that apply) Primary Care Provider Dermatology Hearing Family Planning Medical/Other:	☐ Vision ☐ Dental ☐ Public Health/WIC ☐ Communicable Disease, ID referral for: ☐ Communicable Disease, LHD referral for:			
Mental Health referral for (check as appropriate): □ Depression □ Post traumatic stress disorder (PTSD) □ Depression □ Anxiety □ Adjustment issues □ Domestic issues □ Substance Abuse □ Learning problems □ Other				
Screening provider: If more than one agency is involved in health assessment include information on both agencies.				
Agency One:				
Address:				
Telephone: ()				
Fax: ()				
Submitter:	Contact Number:			
Agency Two:				
Address:				
Telephone: ()				
Fax: ()				
Submitter:	Contact Number:			

Fax completed form to: (515) 281-4570 Or mail completed form to:

Iowa Department of Public Health Attn: Refugee Health Coordinator Lucas State Office Building

321 East 12th Street

Des Moines, Iowa 50319-0075

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