MINNESOTA INITIAL REFUGEE HEALTH ASSESSMENT FORM

DEPARTMENT OF HEALTH

Return completed form, preferably within 30 days of screening completion, to address on bottom of page 3.

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**):** ____/____/_____

Date Screening Completed (month, day, year**):**____/____/_____

Screening Clinic Information

Screening Clinic _____

Physician/PA/NP Last_____ **First** _____

Address _____

City_____ **State** _____ **Zip** _____

Phone _____ **Fax**_____

Name/title person completing form_____

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

Immunizations

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. **Minnesota Immunization Information Connection (MIIC) ID:** _____

☐ Overseas immunizations done

☐ Immunizations **not** given in U.S., reason_____

		Immunization Date(s)					
		Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Diphtheria- Tetanus (DT**)**							
Diphtheria, Tetanus, & Pertussis (DTP, DTaP**)**							
Tetanus- Diphteria (Td**)**							
Tetanus, Diphtheria, Pertussis (Tdap)							
Hepatitis A (Hep A)	☐ Y ☐ N ☐ I						
Hepatitis B (Hep B)							
Haemophilus influenzae type b (Hib)							
Human Papilloma Virus (HPV)							
Influenza							
Measles, Mumps, Rubella (MMR)							
Measles	☐ Y ☐ N ☐ I						
Mumps	☐ Y ☐ N ☐ I						
Rubella	☐ Y ☐ N ☐ I						
Meningococcal conjugate (MCV4)							
Meningococcal polysaccharide (MPSV4)							
Pneumococcal conjugate (PCV7)							
Pneumococcal conjugate (PCV10)							
Pneumococcal conjugate (PCV13)							
Pneumococcal polysaccharide (PPSV23)							
Polio (OPV**)**							
Polio (IPV**)**							
Rotavirus (RV1**)**							
Rotavirus (RV5**)**							
Varicella (VAR)	☐ Y ☐ N ☐ I						
Zoster (shingles**)**							

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 ☐ T-SPOT
☐ Positive
☐ Negative
☐ Indeterminate
☐ Borderline
☐ Not Done

Chest X-Ray – done in U.S.
(If TST or IGRA 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*
☐ Previously treated LTBI
☐ Old, healed prev. Tx TB
☐ Active TB disease – (suspected or confirmed)*
☐ Pending
☐ Incomplete evaluation

*Complete TB treatment section

Treatment
(for TB disease or LTBI)
Start Date: __/__/____
OR Reason for not treating
☐ Declined treatment
☐ Lost to follow-up
☐ Moved out of MN
☐ Pregnancy or Breastfeeding
☐ Medical other than pregnancy
☐ Provider decision
☐ Further evaluation 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 susceptible started on vaccine? _____Yes ____No
☐Contacts not screened → why not? _____

3. Anti-HBc (✓ one) ☐Negative ☐Positive ☐Indeterminate ☐Results pending ☐Not done

Hepatitis C Screening

1. Anti-HCV (✓ one) ☐Negative ☐Positive ☐Indeterminate ☐Results pending ☐Not done; **HCV CONFIRM** ☐Negative ☐Positive

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

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? (✓ one) ☐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 (O&P) Test ☐No parasites found ☐Results Pending
☐Non-pathogenic parasites found ○Blastocystis; treated: ___yes____no ☐Not Done
☐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 ☐E. histolytica Treated? ☐Yes ☐No ☐Hymenolepis Treated? ☐Yes ☐No ☐Paragonimus Treated? ☐Yes ☐No	☐Ascaris Treated? ☐Yes ☐No ☐Dientamoeba Treated? ☐Yes ☐No ☐Clonorchis Treated? ☐Yes ☐No ☐Other (specify) Treated? ☐Yes ☐No
If not treated, why not?		

PLEASE TURN THE PAGE FOR MORE TESTS →

Malaria Screening *(✓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): _____

If malaria species found: Treated? ☐ Yes ☐ No → Referred for malaria treatment? ☐ Yes ☐ No

If referred for malaria treatment, specify physician/clinic: _____

☐ Screened, results pending

Labs and Measurements (*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)	VIT D TOTAL (ng/ml)	LEAD (<17 yrs old)

Other Health Conditions

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

Addtl. 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	☐ Occupational/Physical Therapy
☐ Home Care/PCA	☐ Other Referral _____		

Reimbursement/Insurance Information

☐ Straight MA MHCP/MA ID #:_____ Activation Date: ___/__/__/____/___/____

☐ PMAP (specify health plan):_____ MHCP/PMAP ID #:_____ Activation Date: _____/_____/_____

☐ Private third party payer ☐ Other (specify) _____ ☐ No Insurance

☐ Flat Fee* (*A flat fee reimbursement is available to clinics that screen refugees without health insurance. Must be a primary refugee, screened within 90 days of arrival, and with complete exam. Call (651) 201-5414 for more information.)

Note: Fill out the Minnesota Refugee Health Assessment Form indicating the results of the tests listed on this form and return to the local public health agency noted below within 30 days of completion of screening. For more information, contact the Refugee Health Program, Minnesota Department of Health at: (651) 201-5414.

RETURN/MAIL TO: (Local Public Health Agency)
Address:_____

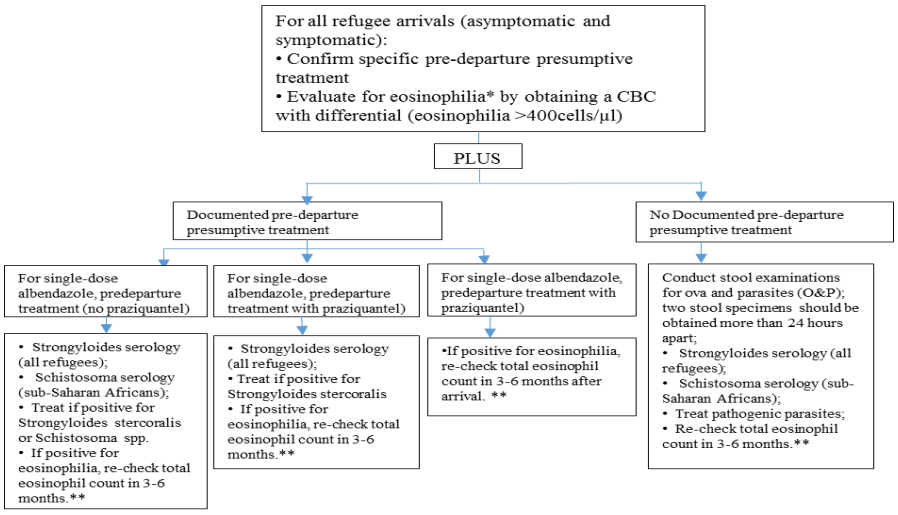
_____

Phone: _____

Revised 01/19

Minnesota Department of Health Initial Health Screening Tests Recommended for All Refugees/Immigrants

Components of Refugee Health Assessment: Complete history, review of systems, physical examination including assessment for infectious disease and chronic disease, and laboratory testing. Infectious diseases continue to be significant and can be readily addressed when identified. There is increased recognition that chronic health disorders are common and may pose greater long-term threat to the individual's health. Health issues to consider include: cardiovascular, hematologic disorders (eosinophilia, anemia, and microcytosis), nutritional deficiencies, dental caries, diabetes, thyroid disease, otorhinologic and ophthalmologic problems, and dermatologic abnormalities. As part of assessment, record blood pressure, pulse, height, weight, head circumference, perform urinalysis for any patient old enough to produce a clean catch specimen, vision and hearing evaluation. More detail see: MN Refugee Health Provider Guide at www.health.state.mn.us/refugee.

Disease or Condition	Screening Recommendations
Immunizations	Assess and update immunizations for each individual. Indicate laboratory evidence of immunity for measles, mumps, rubella, varicella, hepatitis B or hepatitis A, if available; immunizations are not needed if immune. For all other immunizations, update series or begin primary series if immunization dates are not found. If you need assistance translating immunization records or determining needed immunizations, call CDC hotline 800-CDC-INFO (1-800-232-4636). Always update the personal immunization record card.
Tuberculosis (TB)	Perform a tuberculin skin test (TST) or blood interferon gamma 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. • A chest x-ray should be performed for all individuals with a positive TST or IGRA test • 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.
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	

* Eosinophilia may or may not be present with parasitic infection; an absolute eosinophil count provides supplemental diagnostic information. ** Persistent eosinophilia or symptoms requires further diagnostic evaluation.

If parasites are identified, one stool specimen should be submitted 2-3 weeks after completion of therapy to determine response to treatment. For background information and treatment guidelines see CDC's Evaluation of Refugees for Intestinal and Tissue- Invasive Parasitic Infections during Domestic Medical Examination, as well as The Medical Letter on Drugs and Therapeutics: Drugs for Parasitic Infections.

Sexually Transmitted Infections	Routine screening for HIV, ages 13- 64 years using Anti-HIV 1+2 assay; universal testing of HIV and syphilis for arrivals from areas of the world with high prevalence of HIV/AIDS. Screen for syphilis by administering VDRL or RPR. Confirm positive VDRL or RPR by FTA-ABS/MHATP 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 STDs if indicated by self-report or endemicity in homeland.
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 wellbeing (e.g., sleeplessness, headaches, nightmares, irritability).

NOTICE FOR HEALTHCARE PROVIDERS REGARDING RELEASE OF INFORMATION

Information on this Refugee Health Assessment Form is collected for the Minnesota Department of Health (MDH), by authority of 8 U.S. Code Chapter 12, Subchapter IV, Section 412(c)(3)* of the Immigration and Nationality Act. The information you or your clinic provide is used to obtain a health evaluation and/or treatment for the patient. It can also facilitate the individual's enrollment into a school, child care, or early childhood programs as required by Minnesota Statutes §121A.15. MDH may release this information on the form to health care providers or agencies which are involved in the care of the individual. These health care providers and agencies usually include medical, mental and dental care providers, public health agencies, hospitals, schools, child care centers and early childhood programs. All public health agencies, health institutions, or providers to whom the refugee has appeared for treatment or services will be entitled to the information included on this form.

Although some of the information collected includes legally reportable diseases (MN Rules Chapter 4605), there is no obligation to provide supplemental information and the client will receive health care services even if your entity does not provide the supplemental information. However, if the information is not provided, it may result in delay of services or denial of enrollment into a Minnesota school, child care center or early childhood program because information may not be shared with agencies.

MDH protects private data in accordance with the Government Data Practices statutes, Minnesota Statutes, Chapter 13.

Why is MDH asking for the information?

- To help the patient get medical, dental, or mental health services to ensure they receive appropriate health care;
- For school, child care, or early childhood enrollment to aid in enrollment in these programs;
- To make reports, do research, conduct audits, evaluate refugee programs and develop interventions and educational/outreach activities to ensure refugees received appropriate health care.

With whom may this information be shared?

- Healthcare providers, including medical, mental and dental healthcare providers, public health agencies, and hospitals involved in the care of the refugee
- Schools, child care centers or early childhood programs, for enrollment
- Local, state, or federal public health agencies conducting program evaluations to ensure refugees receive appropriate care.

For more information, contact:
The Refugee Health Program
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
St Paul, MN 55164-0975
(651) 201-5414 (metro)
1-877-676-5414 (toll-free)
www.health.state.mn.us/refugee

DEPARTMENT OF HEALTH