



TEXAS REFUGEE HEALTH ASSESSMENT FORM

Alien # _____ File # _____

Last Name: _____ First and Middle Name: _____

Date of Birth (mm/dd/yyyy): _____ Gender: M F

Arrival Status: R A P VT SIV U.S. Arrival Date (mm/dd/yyyy): _____

Country of Origin (of refugee group): _____ City of Residence: _____

County (of clinic): _____ Voluntary Agency: _____

Overseas Classifications: TB Class: B1 B2 History of Overseas Immunizations

Overseas Medical Conditions (from list): _____

I-693 Completed Secondary Migrant From (TX county or U.S. state): _____

First Screening Date (mm/dd/yyyy): _____ Medical Record # _____

Vaccine-Preventable Disease / Immunization	Is there is evidence of immunity?	Domestic Immunization Date(s) (MM/DD/YYYY)				
MMR						
Varicella						
Hepatitis A						
Hepatitis B						
Diphtheria, Tetanus, Pertussis (DTap)						
Tetanus, Diphtheria, Pertussis (Tdap)						
Tetanus, Diphtheria (Td)						
Polio						
<i>Haemophilus influenzae</i> type b (Hib)						
Rotavirus						
Meningococcal						
Influenza						
Pneumococcal						
Human Papillomavirus (HPV)						
Zoster						

TB Screening:

1. Tuberculin Skin Test (TST) mm Induration: _____

IGRA Test Only *Not Done*: Past history of positive TST Given, not read Declined test Tested elsewhere
 Previous severe reaction

2. IGRA Test: Positive Negative Indeterminate

Hepatitis Screening:

1. Hepatitis B: Not done, why not? _____

Anti-HBs: Negative Positive HBSAg: Negative Positive Anti-HBc: Negative Positive

2. Hepatitis C (Optional): Negative Positive

Alien # _____ Last Name: _____

Sexually Transmitted Infections:

- 1. Syphilis Negative Positive Not done, why not? _____
- 2. Chlamydia (Females Age 15-25 Only) Negative Positive Not done, why not? _____
- 3. HIV Negative Positive Not done, why not? _____
- 4. Other, specify: _____ Negative Positive

Intestinal Parasite Screening:

Ova & Parasite Tests:

- Not screened for parasites; why not? _____
- Screened, no parasites found
- Screened, non-pathogenic parasites found
- Screened, pathogenic parasites found (*check all that apply*):
- Screened, BOTH pathogenic and non-pathogenic parasites found (*check all that apply*):

<input type="checkbox"/> Ascaris	<input type="checkbox"/> Hookworm
<input type="checkbox"/> Clonorchis	<input type="checkbox"/> Schistosoma
<input type="checkbox"/> Dientamoeba	<input type="checkbox"/> Strongyloides
<input type="checkbox"/> Entamoeba histolytica	<input type="checkbox"/> Trichuris
<input type="checkbox"/> Giardia	<input type="checkbox"/> Other: _____

CBC with differential done? Yes No If not done, why not? _____
If yes, was Eosinophilia present? Yes No If yes, was further evaluation done? Yes No

Serology Tests:

Schistosoma (Sub-Saharan Africans Only) Negative Positive Not done, why not? _____
Strongyloides Negative Positive Not done, why not? _____

Currently Pregnant: Yes

Malaria Screening (Sub-Saharan Africans Only):

- Not screened for malaria; why not? _____
- Screened, no malaria species found in blood smears
- Screened, malaria species found (*please specify*): _____

Hemoglobin (m/dL):	Hematocrit (%):	Lead Screened? <input type="checkbox"/> Yes <input type="checkbox"/> No (6 months - 16 yrs.) BLL (µg /dl):	Height (in):	Weight (lbs):	BP-Systolic (mm Hg):	BP- Diastolic (mm Hg):
--------------------	-----------------	--	--------------	---------------	----------------------	------------------------

If any of the boxes are left blank (besides lead), please check the following box and provide a reason: Not done, why not? _____

- 1. Cholesterol Not Elevated Elevated Not done, why not? _____
- 2. UA Normal Abnormal Not on protocol Not done, why not? _____
- 3. B/CMP Done Not done, why not? _____

Referrals (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Primary Care | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Hearing | <input type="checkbox"/> Family Planning |
| <input type="checkbox"/> WIC | <input type="checkbox"/> Dermatology | <input type="checkbox"/> TB Program |
| <input type="checkbox"/> GI | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Ear, Nose & Throat (ENT) | <input type="checkbox"/> Cardiology | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Hematology | <input type="checkbox"/> Ortho | <input type="checkbox"/> Pulmonology |
| <input type="checkbox"/> Other Referral: _____ | <input type="checkbox"/> Disability (type): _____ | <input type="checkbox"/> Emergency /Urgent Care (reason): _____ |

Interpreter needed: Yes No If Yes, language needed: _____

Date screening completed (mm/dd/yyyy): _____ Date submitted to DSHS (mm/dd/yyyy): _____

Outcome (if applicable)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Moved out of state: _____ | <input type="checkbox"/> Unable to locate | <input type="checkbox"/> Never arrived | <input type="checkbox"/> Hospitalized |
| <input type="checkbox"/> Moved out of county: _____ | <input type="checkbox"/> Missed appointment | <input type="checkbox"/> Died before screening | <input type="checkbox"/> Vaccines Only |
| <input type="checkbox"/> Moved to unknown destination | <input type="checkbox"/> Screened elsewhere- no results | <input type="checkbox"/> Refused screening | |