

## WISCONSIN INITIAL REFUGEE HEALTH ASSESSMENT

### Instructions:

The refugee health assessment must be done with a trained medical interpreter or a medical provider fluent in the refugee's language. The purpose of this form is to assess the initial health status of refugees entering Wisconsin. Completion of this form is voluntary.

**Perform the following lab tests as appropriate as part of the initial refugee health assessment:**

- Varicella screening if no verification of natural immunity
- Hepatitis B screening (anti-HBs, HBsAg, anti-HBc and IgM anti-HBc)
- Intestinal parasite screening, provide containers and instruct client with interpreter on collecting and returning specimens to the appropriate provider (e.g. clinic, local health department)
- Syphilis, Gonorrhea, Chlamydia and HIV testing
- CBC with differential
- Hemoglobin/hematocrit
- Urinalysis/pregnancy test
- Malaria screening if history or symptoms are suspicious of malaria
- Lead (children ages 6 months to 16 years of age within 90 days of arrival in the U.S.; children ages 6 months to 6 years (and older children if warranted) 3 to 6 months after placement into a permanent residence, regardless of initial test results).
- Tuberculosis (TB) testing
- UA/UC (Urinalysis/Urine culture)
- Other labs as appropriate for follow-up

**Prior to initiating the health screening, verify the patient's admission status.**

**Admission status** refers to the classification that allows the patient to legally remain in the United States. To identify a patient's status:

- Request they present their Arrival/Departure Record (form I - 94) or a letter from the Office of Refugee Resettlement or from an immigration judge that documents the patient's status.
- Review the item and identify whether the patient's status is that of a Refugee, Asylee, Cuban/Haitian Entrant, Victim of Trafficking, or an Amerasian.

**Complete all information; Name, Date of Birth, Gender, Voluntary Agency (VOLAG)\*, Alien Number, Country of Origin, Race, U.S. Arrival Date, Date of first clinic visit, Class B Status\*\*, and reimbursement information in space provided at the top of page 3.**

\***VOLAG** refers to refugee resettlement **voluntary agency**.

\*\***Class B status** refers to a condition (mental or physical) that was identified on the overseas medical examination prior to immigration to the United States. This condition represents a departure from normal health or well-being that is significant enough to possibly interfere with the person's ability to care for himself or herself, or to attend school or work, or that may require extensive medical treatment or institutionalization in the future.

**Assess immunizations:** Review overseas medical exam (DS 2053) if available, and document immunization dates. According to the Advisory Committee on Immunization Practices (ACIP):

- Refugees <19 - update series, or begin primary series if no immunization dates are documented.
- Refugees ≥19 - assess for vaccines that are medically appropriate.

For measles, mumps, and rubella indicate if there is **laboratory** evidence of immunity; if so, immunizations are not needed against those particular diseases. MMR vaccine can satisfy the immunization requirements for Measles, Mumps and Rubella.

For varicella, if there is laboratory evidence of immunity or **reliable** history of the disease (e.g. dermatological manifestations), immunization is not needed.

Document immunization information on the Refugee Health Assessment. Always update the personal immunization record card and instruct the patient and/or family, using an interpreter when needed. Call the Wisconsin Immunization Program at (608) 267-9959 for free immunization consultation if needed. **NOTE:** 07/2008 United States Citizenship and Immigration Service (USCIS) increased the vaccinations required for refugees seeking adjustment of status: [http://www.cdc.gov/ncidod/dq/pdf/civil\\_surgeon\\_ti/memo\\_.pdf](http://www.cdc.gov/ncidod/dq/pdf/civil_surgeon_ti/memo_.pdf)

### **Tuberculosis Screening:**

Apply Mantoux skin test to all patients regardless of BCG history, unless a rare medical contraindication is present. (Pregnancy is not a medical contraindication for Mantoux testing.)

Apply Mantoux skin test to all patients 6 months or under if the child has HIV infection or if the child was exposed to an individual with active TB disease. (Make an immediate public health referral on a child with these circumstances.)

The TB blood assay test (BAT) such as Quantiferon Gold™ or T-Spot™ may be used in place of the Mantoux for all persons over the age of 17. No published data document the performance of QFT-G in children aged <17 years [CDC/MMWR 12/16/05/54 (RR15); 49-55].

Schedule a child under 6 months of age, who is not HIV+ or a close contact, for a repeat Mantoux skin test after their 6-month birthday.

**Tuberculosis Screening Continued:**

Read Mantoux test in 48-72 hours and record results in millimeters of induration and/or record results of Blood Assay Test (BAT) on page three of this form.

For all positive tests, record skin test /BAT and chest x-ray information on the Wisconsin TB Record form number DPH 4756 and provide to patient/family to facilitate initiation of treatment for latent TB infection or disease.

Indicate if the refugee has any medical risk factors, which increase the risk for breaking down with active TB disease such as immunosuppression, low body weight, diabetes, etc.

Chest x-ray MUST be done if:

- Mantoux is positive (for the person's risk factors) or blood assay test is positive
- Patient has been identified on their overseas medical exam (DS 2053) as having a class A or B TB condition
- Patient is symptomatic (cough, fever, hemoptysis, night sweats, weight loss, etc.)
- Patient is a recent contact, overseas or stateside, to active TB disease (Make an immediate public health referral.)

Indicate on the assessment form if medications for TB disease or TB infection were prescribed. All suspect or confirmed cases of TB should be reported immediately by telephone to the local health department.

**Oral Health:**

Complete in accordance with DPH oral health training. Check screening "not done" if you have **not** been trained. **Ensure that oral health screening is initiated if you are unable to do it.**

**Hepatitis B**

Administer Hepatitis B screening panel including Hepatitis B surface antigen (HBsAg), Hepatitis B surface antibody (anti-HBs), anti-HBc and IgM anti-HBc. Screen all household contacts of carriers and immunize susceptibles. Refer those who are HBsAg positive for additional medical evaluation.

**Consider HIV and STD screening for all persons who have reached sexual maturity or have a risk factor for HIV or an STD (family exposure, sexual abuse, etc.)**

HIV testing requires a separate written consent, according to Wis Statute 252.15(2).

Screen for syphilis by administering VDRL or RPR. Confirm positive VDRL or RPR by FTA-ABS/TPPA or other confirmatory test. Repeat VDRL/FTA in 2 weeks if lesions typical of primary syphilis are noted and person is seronegative on initial screening.

Screen for Chlamydia and gonorrhea using appropriate tests (even if asymptomatic).

Screen for other STDs if symptomatic, if patient reports possible exposure, or you suspect exposure related to abuse.

**Intestinal Parasites:**

Evaluate for eosinophilia by obtaining a CBC with differential.

Conduct stool examinations for ova and parasites. Three stool specimens should be obtained at least 24 hours apart.

- If parasites are identified, one stool specimen should be submitted 2-3 weeks after completion of therapy to determine response to treatment.
- Eosinophilia requires further evaluation for pathogenic parasites, even with 3 negative screening stool examinations.

**NOTE:** The Wisconsin Division of Public Health **does not** recommend the use of rapid tests for identification of these parasites.

**Blood work:** Document results.

**Pregnancy:** Test if indicated and provide appropriate care or referrals.

**Malaria:** If symptomatic, obtain three thick and three thin smears to screen for malarial parasites.

**Lead:** Include lead testing when ordering lab work for children between ages 6 months to 16 years of age within 90 days of arrival in the US and for children ages 6 months to 6 years (and older children if warranted) 3-6 months after placement into a permanent residence, regardless of initial test results). <http://www.cdc.gov/nceh/lead/Refugee%20recs.htm> or <http://www.cdc.gov/nceh/lead/Publications/RefugeeToolkit/pdfs/CDCRecommendations.pdf>

**Assess for other health problems:**

Hematological disorders (eosinophilia, anemia, microcytosis), dental caries, nutritional deficiencies, thyroid disease, otorhinologic and ophthalmologic problems, history of trauma, dermatological abnormalities. **Height, weight, vision and hearing evaluation and blood pressure.** Assess mental health needs (e.g., headaches, nightmares, and depression). Screen for suicide potential if indicated and provide appropriate referrals.

**Communicable Disease Reporting:**

Wisconsin statute Chapter 252.05 and administrative Rule Chapter HFS 145 require reporting of suspect and confirmed communicable diseases. - Refer to **Acute and Communicable Disease Case Report – F-44151**. Indicate on all referrals made for patient and if an interpreter is needed. Fill in all lab results in appropriate places throughout the form.

Write name, address, phone/fax number and contact person of the agencies that provide the health screening on page 3. Include the Physician/PA/NP name and date completed. **Fax** all completed forms to **(608) 266-0049** or **mail** to: **Refugee Health Coordinator, PO Box 2659, Madison WI 53701-2659**. For questions or further information on refugee health screening call the Wisconsin Refugee Health Coordinator at: (608) 267-3733.

## WISCONSIN INITIAL REFUGEE HEALTH ASSESSMENT

Client information is confidential under Wisconsin Statute 146.82 (1)  
 Read instructions before completing this form.

**Admission Status:**  Refugee  Asylee  Cuban/Haitian  Victim of Trafficking  Amerasian

**Name** (last, first, middle): \_\_\_\_\_

**Gender:** \_\_\_\_\_ **Date of Birth** (month, day, year): \_\_\_\_\_ **Resettlement Agency/VOLAG:** \_\_\_\_\_

**Alien or Visa Registration No.:** \_\_\_\_\_ **File/Case No.:** \_\_\_\_\_ **Country of Origin:** \_\_\_\_\_ **Race:** \_\_\_\_\_

**U.S. Arrival Date** (month, day, year): \_\_\_\_\_ **Date of First Clinic Visit for Screening** (month, day, year): \_\_\_\_\_

**Class B Status:** **How will clinic be reimbursed for this screening?**  Medical Assistance  Health Screening Contract  Other **Interpreter Needed?**  Yes  No  
 If yes which language? \_\_\_\_\_ **Literate in own language?**  Yes  No

Vaccine- Preventable Disease/Immunization	Check if there is evidence of immunity; no immunization needed	Immunization Date(s)					
		Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Measles	<input type="checkbox"/>						
Mumps	<input type="checkbox"/>						
Rubella	<input type="checkbox"/>						
Varicella (VZV)	<input type="checkbox"/>						
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)	<input type="checkbox"/>						
Diphtheria Tetanus (Td) / Tdap*	<input type="checkbox"/>						
Polio (IPV, OPV)	<input type="checkbox"/>						
Hepatitis B (Hep B)	<input type="checkbox"/>						
Haemophilus influenzae type b (Hib)	<input type="checkbox"/>						
Hepatitis A (Hep A)	<input type="checkbox"/>						
Influenza	<input type="checkbox"/>						
Pneumococcal	<input type="checkbox"/>						
Human Papillomavirus (HPV)	<input type="checkbox"/>						
Meningococcal conjugate (MCV)	<input type="checkbox"/>						
Rotavirus	<input type="checkbox"/>						
Zoster (shingles)	<input type="checkbox"/>						

\*Tetanus, diphtheria and acellular pertussis (Tdap) vaccine can satisfy the Td booster requirement. Tdap vaccine is licensed for individuals 10 through 64 years of age.

**Tuberculosis Screening:**

**Mantoux Skin Test Reaction** (check one)

Given regardless of history of BCG.

Results:  
 Date Placed: \_\_\_\_\_  
 Date Read: \_\_\_\_\_  
 \_\_\_\_\_mm induration

Not done

**Blood Assay Test (BAT) Date:** \_\_\_\_\_

**Result:**  
 Positive  Negative  Indeterminate

**Risk factors for TB disease:**

Medical risk factor (diabetes, immunosuppression, substance abuse, low body weight, etc.)

Explain: \_\_\_\_\_

**Chest x-ray:** (taken in U.S.) (check one)

- Normal
- Non-TB Abnormality
- TB- non-cavitary
- TB- cavitary
- Stable, old TB
- Pending
- Not done, explain: \_\_\_\_\_

**TB Therapy:** (if indicated) (check one)

- Treatment for suspected or confirmed active TB prescribed  
Date started: \_\_\_\_\_
- Treatment for latent TB infection (LTBI) prescribed;  
Date started: \_\_\_\_\_
- No LTBI treatment; Reason:  
 Documented treatment overseas for active TB disease completed  
 Pregnancy, HIV neg., no recent contact to active TB case  
 Refused  
 Other: \_\_\_\_\_

**Oral Health:** (check all that apply)

<input type="checkbox"/> Screening not done	<input type="checkbox"/> Caries experience	Comments: _____	Treatment urgency:	
<input type="checkbox"/> Untreated caries	<input type="checkbox"/> No natural teeth	<input type="checkbox"/> Periodontal disease risk factors	<input type="checkbox"/> Early	<input type="checkbox"/> No obvious problem
<input type="checkbox"/> Early Childhood Caries	<input type="checkbox"/> Sealants present	<input type="checkbox"/> Signs of inflammation present	<input type="checkbox"/> Urgent	<input type="checkbox"/> Prevention
		<input type="checkbox"/> Signs of inflammation present		

**Hepatitis B Screening**

**Anti-HBs** (check only one)     Negative     Positive; Note: if positive, patient is immune     Results pending

**HbsAg** (check only one)     Negative     Positive     Results pending

Note: If positive, patient is infected with HBV and infectious to contacts, and it is especially important to screen all household contacts.  
 If positive HbsAg, were all household contacts screened?     Yes     No  
 If Yes, were all susceptibles started on vaccine?     Yes     No    If No, why not?

Referred for follow-up?     Yes     No

**Anti-HBc** (check only one)     Negative     Positive     Results pending     Not done

**IgM anti-HBc** (check only one)     Negative     Positive     Results pending     Not done

Note: If positive, patient has acute HBV infection.  
 If positive IgM anti HBC was patient referred for follow-up?     Yes     No

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

**HIV\***     Negative     Positive; referred to specialist?     Yes     No     Testing Not done, why? \_\_\_\_\_

**Syphilis**

Screening tests (VDRL/RPR)     Negative     Positive; treated?     Yes    Tx: \_\_\_\_\_     Not done, why? \_\_\_\_\_

Confirmation test (FTA/TPPA)     Negative     Positive; treated?     Yes    Tx: \_\_\_\_\_     Not done, why? \_\_\_\_\_

**Gonorrhea**     Negative     Positive; treated?     Yes     No     Results pending     Not done, why? \_\_\_\_\_

**Chlamydia**     Negative     Positive; treated?     Yes     No     Results pending     Not done, why? \_\_\_\_\_

**Other, specify:**     Negative     Positive; treated?     Yes     No     Results pending     Not done, why? \_\_\_\_\_

\*If HIV testing is done, a separate signed consent form for HIV testing must be completed.

**Intestinal Parasite Screening:**

Was screening for parasites done?     Screened, results pending     Screened, no parasites found     Screened, parasite(s) found:  
 (Check all that apply)

<input type="checkbox"/> Ascaris	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hookworm	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Clonorchis	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Schistosoma	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cryptosporidium	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Strongyloides	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cyclospora	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trichinella	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Entamoeba histolytica	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trichuris	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Giardia	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other Specify: _____	Treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Parasites not treated, why: \_\_\_\_\_     Not screened for parasites; why? \_\_\_\_\_

**Blood Work**

CBC with differential done?     Yes     No    Hemoglobin     Results: \_\_\_\_\_     Not done

Was Eosinophilia present?     Yes     No     Results pending    Hematocrit     Results: \_\_\_\_\_     Not done

If yes, was further evaluation done?     Yes     No    ALT: \_\_\_\_\_    AST: \_\_\_\_\_

Other: \_\_\_\_\_

**Lead screening:** (check only one)     Yes    Results: \_\_\_\_\_     No     N/A

**Currently pregnant:** (check only one)  Yes; expected date of delivery \_\_\_\_\_  No  Not tested

**Malaria Screening:** (check only one)

Not screened for malaria (not symptomatic)  Screened, results pending  Screened, no malaria species in blood smears found

Ovale  Falciparum  Vivax  Malariae  Not identified

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

If referred for malaria treatment, specify physician/clinic:

**Significant information from patient history:** \_\_\_\_\_

**Significant information from physical exam:** \_\_\_\_\_

**Communicable Disease Reporting:**

**Wisconsin statute Chapter 252.05 and administrative Rule Chapter HFS 145 require reporting of suspect and confirmed communicable diseases. Refer to Acute and Communicable Disease Reporting - DPH 4151**

**Referrals: (check all that apply)**

Primary Care Provider

Vision

Dermatology

Communicable Disease, ID referral

for: \_\_\_\_\_

Communicable Disease, LHD referral

for: \_\_\_\_\_

Dental

Hearing

Public Health/WIC

Family Planning

Medical/Other: \_\_\_\_\_

**Mental Health referral for (check as appropriate):**

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:** \_\_\_\_\_ **Agency Two:** \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) Telephone: ( \_\_\_\_\_ )

Fax: ( \_\_\_\_\_ ) Fax: ( \_\_\_\_\_ )

**Submitter:** \_\_\_\_\_ **Contact Number:** \_\_\_\_\_

Fax completed form to the Wisconsin Department of Health Services, Division of Public Health, Bureau of Communicable Diseases, Refugee Health Coordinator at **(608) 266-0049** or mail to:

Division of Public Health  
Attn: Refugee Health Coordinator  
PO Box 2659  
Madison WI 53701-2659

**Statement of Rights**

Information on this form is collected for the Wisconsin Division of Public Health (DPH), by authority of Section 412(7) of the Immigration and Nationality Act as amended by the Refugee Act of 1980. This information is used to obtain a health evaluation and/or treatment for the patient. Wisconsin State Statute authorizes collection of this information under s. 250.04. In order to provide services, it may be necessary to release information from the patient's record to individuals or agencies that are involved in the care of the individual. Such individuals and agencies usually include family physicians and/or dentists, medical and dental specialists, public health agencies, hospitals, schools and day care centers. All public health agencies, health institutions, or providers to whom the refugee has appeared for treatment or services shall be entitled to the information included on this form.