

**MARYLAND REFUGEE HEALTH ASSESSMENT FORM**

**TOTAL HEALTH ASSESSMENT FEE \$300 (Level I and Level II)**

Initial Screening Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Alien Number: \_\_\_\_--\_\_\_\_--\_\_\_\_

Asylee Granted Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sponsor/Contact Person: \_\_\_\_\_

Provider Agency/County: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

**NAME:**  
**Last** \_\_\_\_\_ **First** \_\_\_\_\_ **Middle** \_\_\_\_\_

**SEX:** Male  Female  **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age** \_\_\_\_ **Country of Origin** \_\_\_\_\_ **Date of Arrival in U.S.A** \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this person pregnant Yes  No

**IMMIGRATION STATUS:** AmerAsian  Parolee  Asylee  Refugee  ODP Immigrant  Other   
 Haitian/Cuban Entrant  **Migration Status:** Primary  Secondary

**SCREENING STATUS:** Screened  Did not keep appointment  Refused service  Unable to locate   
 Migrated before screening  Screened by private provider  Referred  Where \_\_\_\_\_

**BASIC HEALTH SCREENING (Former level I) - \$105**

Medical History Review:  Yes  No

Overseas Medical Records Review  Yes  No

Physical Examination:  
 Height: \_\_\_\_Ft \_\_\_\_inch Weight: \_\_\_\_lbs

	Normal	Abnormal	Treated	Referred
Blood Pressure	_____	_____	_____	_____
Heart	_____	_____	_____	_____
Lung	_____	_____	_____	_____
Skin	_____	_____	_____	_____
ENT:	_____	_____	_____	_____
Gross Vision	_____	_____	_____	_____
Gross Dental	_____	_____	_____	_____
Aneamia (HCT)	_____	_____	_____	_____
Other:	_____	_____	_____	_____

**HEALTH RISK ASSESSMENT (Former Level II) -(\$195)**

**HEPATITIS B**

Screened for Hepatitis B: Yes  No  Not Applicable

Test Results: HbsAG: Positive  Negative  Referred

Anti-HBs: Positive  Negative

Counseling on the Disease: Yes  No

**Status:** Carrier  Immune  Susceptible  Acute Case

**Contact:** # Household \_\_\_\_ # Sex contact \_\_\_\_  
 # immunized \_\_\_\_ # Referred \_\_\_\_

**PARASITES**

Screened for parasites: Yes  No  Not Applicable

Parasites present: Yes  No  Referred

If Present, Parasites type: Ascaris  Clonorchis   
 E.Coli  Giardia  Hookworm  Trichuris   
 Strongyloides  Other Specify \_\_\_\_\_ Treated: Yes  No

**BLOOD LEAD LEVEL:** Tested- Yes  No  Not Applicable

If tested, Date Tested: \_\_\_\_/\_\_\_\_/\_\_\_\_,  
 Result: Positive  Negative  Treated  Referred

**SEXUALLY TRANSMITTED DISEASE (STD)**

Syphilis screening done overseas: Yes  No

Test done in US: Yes  No  Not applicable

Needs follow-up

RPR/VDRL Reactive  Non-Reactive  FTA

Treated Yes  No  Not Applicable  Referred

**IMMUNIZATIONS:**

Immunization Records Review: Yes  No  Not Applicable

Administered: DT/aP  OPV/IPV  HIB  HBV

Varicella  MMR  Pneumooccal

Others - specify \_\_\_\_\_ Referred: Yes  No

**TUBERCULOSIS (TB):** Class B1  B2  B3

Skin Test done: Yes  No  if "Yes" Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 PPD reading: \_\_\_\_mm Did not return for PPD reading

Overseas Chest x-ray Reviewed: Yes  No  Not Applicable   
 Normal  Abnormal  Not Available

U.S. Chest x-ray done: Yes  No  Unknown   
 Result: Normal  Abnormal  Cavitory  Non-Cavitory   
 TB Suspect  Active TB  Treated  Referred

**Treatment of Latent TB Infection (TLTBI):**

Started: Yes  No  if "Yes" Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 If "No", reasons: Moved  Refused  Pregnant   
 Not recommended  Referred

**FINDINGS OF CONDITIONS THAT NEED FURTHER EVALUATION/TREATMENT:**

	Treated	Referred	Class B	Other
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Signature of Health Provider: \_\_\_\_\_

## Instructions to Complete the Maryland Refugee Health Assessment DHMH 4391 Form

1. In the first column, fill in date of Initial screening, Client – Refugee or Asylee Alien Number, Sponsor/Contact person, County/Provider Agency name including phone number in the space provide
2. In the Second column, fill in the Client – Refugee or Asylee last, First, and Middle Name in the space provided
3. In the third column, fill in Client (Refugee/Asylees) Gender, Birth date, Age, Country of Origin, and Date of Arrival in the space provided and if the client is a female, check her pregnancy status and circle the response variable as “Yes or No”.
4. In the fourth column, review the refugee/asylee notification documents, identify his/her immigration status and check one of the category box accordingly
5. The fifth column consists of six sections. These are as follows:
  - The first section is **Health Assessment in general** - review current and overseas medical history, perform physical examination and write the results in the space provide under each finding
  - Second section - **Tuberculosis (TB) Screening** – identify Class B status, apply Mantoux skin test regardless of BCG history; read Mantoux test in 48 – 72 hours; Review overseas chest x-ray; if Mantoux skin test is positive chest x-ray must be done, then based on chest x-ray result identify TB status, record the date if he/she start treatments for latent TB infection or referred
  - The third section is **Hepatitis B Screening**-that consist of test of HBsAG, Anti-HBs, counseling on the disease, based on the test results indicate the status by marking in the box.
  - The fourth section is **Sexually Transmitted Disease (STD) Screening**,- review the overseas result and determine whether he/she needs to repeat the test and provide treatment accordingly or if not refer.
  - The fifth section is **Parasites Screening** – since most of the refugees and immigrants come from countries where different types of parasites are endemic and needs to be tested and mark the results on the box
  - **Blood Lead Level Testing/Screening** is an important service to all newly arrival refugee children less than 7 years old who came from Sub-Sahara Africa region. These children are at high risk for lead poisoning for several reasons such as poor nutritional status, parental lack of knowledge about lead hazards, and others. So, please check each notification and identify their country of origin and provide blood lead level testing. Mark the test results in the box provided.
  - **Immunizations Screening**- review the overseas immunization documents and determines to provide missing or continue immunization schedule.
6. The last column is where other findings or conditions and action taken can be stated in term of treatment, referral or other services given.
7. Write the name or signature of Health Provider or Case Manager
8. Mail completed DHMH 4391 Form to Division of TB Control, Refugee & Migrant Health, DHMH.

**Health Assessment Fee: Basic Health Screening** (Former Level I)- **(\$105)** include Medical History review and TB screening,; **Health Risk Assessment** (Former Level II) - **(\$195)** includes Hepatitis B screening, Parasites & Blood lead level testing, Immunization records review/update, STD, and Referral reports.