

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

For Use in Canada Only



Photo

Name (Last, First, MI.) _____, _____, _____
Birth Date (mm-dd-yyyy) _____ **Sex:** M F
Birthplace (City/Country) _____ / _____
Present Country of Residence _____ **Prior Country** _____
U.S. Consul (City/Country) _____ / _____
Passport Number _____ **Alien (Case) Number** _____

Date (mm-dd-yyyy) of Medical Exam _____ **Date** (mm-dd-yyyy) of Prior Exam, if any _____
Date Exam Expires (6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy) _____
Exam Place (City/Country) _____ / _____ **Panel Physician** _____
Radiology Services _____ **Screening Site (name)** _____
Lab (name for HIV/syphilis/TB) _____ / _____ / _____

(1) Classification (check all boxes that apply):

No apparent defect, disease, or disability (see Worksheets 1, 2, and 3)

Class A Conditions (From Past Medical History and Physical Examination Worksheets)

<input type="checkbox"/> TB, active, infectious (Class A, from Chest X-Ray Worksheet) <input type="checkbox"/> Syphilis, untreated <input type="checkbox"/> Chancroid, untreated <input type="checkbox"/> Gonorrhea, untreated <input type="checkbox"/> Granuloma inguinale, untreated <input type="checkbox"/> Lymphogranuloma venereum, untreated	<input type="checkbox"/> Human immunodeficiency virus (HIV) <input type="checkbox"/> Hansen's disease, lepromatous or multibacillary <input type="checkbox"/> Addiction or abuse of specific* substance without harmful behavior <input type="checkbox"/> Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur <p style="font-size: small;">*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics</p>
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Class B Conditions (From Past Medical History and Physical Examination Worksheets)

<input type="checkbox"/> TB, active, noninfectious (Class B1, from Chest X-Ray Worksheet) Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed <input type="checkbox"/> TB, inactive (Class B2, from Chest X-Ray Worksheet) Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed See Section 4 on page 2 for TB treatment details <input type="checkbox"/> Syphilis (with residual deficit), treated within the last year <input type="checkbox"/> Other sexually transmitted infections, treated within last year <input type="checkbox"/> Current pregnancy, number of weeks pregnant _____ <input type="checkbox"/> Other (specify or give details on checked conditions from worksheets) _____ _____ _____	<input type="checkbox"/> Hansen's disease, prior treatment <input type="checkbox"/> Hansen's disease, tuberculoid, borderline, or paucibacillary <input type="checkbox"/> Sustained, full remission of addiction or abuse of specific* substances <input type="checkbox"/> Any physical or mental disorder (excluding addiction or abuse of specific* substance but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur <p style="font-size: small;">*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics</p>
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(2) Laboratory Findings (check all boxes that apply):

Syphilis: **Not done**

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Titer 1	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>		
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>		
Treated	If treated, therapy:				Date(s) treatment given (3 doses for penicillin)	
<input type="checkbox"/> Yes	<input type="checkbox"/> Benzathine penicillin, 2.4 MU IM					
<input type="checkbox"/> No	<input type="checkbox"/> Other (therapy, dose):E					

HIV: **Not done**

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Indeterminate	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Secondary			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(3) Immunizations (See Vaccination Form, check all boxes that apply) **Not required for refugee applicants.**

- Vaccine history complete Vaccine history incomplete, requesting waiver (*indicate type below*)
- Incomplete vaccine history, no waiver requested Blanket waiver Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature

Panel Physician Signature

Date (mm-dd-yyyy)

(4) Tuberculosis Treatment Regimen

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

- Check if therapy currently prescribed (*if current, don't mark "End Date"*)

<u>Medication</u>	<u>Dose/Interval</u> <i>(i.e., mg/day)</i>	<u>Start Date</u> <i>(mm-dd-yyyy)</i>	<u>End Date</u> <i>(mm-dd-yyyy)</i>
<input type="checkbox"/> Isonaizid (INH)	_____	_____	_____
<input type="checkbox"/> Rifampin	_____	_____	_____
<input type="checkbox"/> Pyrazinamide	_____	_____	_____
<input type="checkbox"/> Ethambutol	_____	_____	_____
<input type="checkbox"/> Streptomycin	_____	_____	_____
<input type="checkbox"/> Other, specify	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Applicant's weight (kg) _____

Remarks _____

