

**Pre exam: Health case details**

Panel Physician Report on Medical Examination and Vaccination Record

OMB Control Number <OMB Control number>  
 Form Number DS-7794  
 Expiration Date 09/30/2020  
 Estimated Burden 60 minutes

Client personal details

Surnames <Family name>  
 Given names <Given name(s)>  
 Sex <Sex>  
 Birth date <Dd Mmm yyyy>  
 Birthplace (Country) <Country (DEPT)>  
 Birthplace (City)   
 Prior Country of Residence

Client identity details

Document type Original Passport  
 Document Number <number>  
 Issuing Country <country (ICAO)>  
 Date of issue <Dd Mmm yyyy>  
 Date of expiry <Dd Mmm yyyy>  
 Source

Other Identifiers

Identifier type	Identifier value
Case ID	456789456
CEAC barcode	8978335

Client visa details

Applicant Category NIV - Non-Immigrant Visa

Client declaration

\* I declare that NAME (or their parent/guardian) has read and understands the information provided by the U.S. Department of State regarding eMedical and has agreed to his/her medical information being submitted electronically to the Department, with this consent to be recorded by this clinic in eMedical.

<User name>

<Today's date (dd Mmm yyyy)>

Name of parent/guardian

Relationship to the client

[View client declaration](#)

Contact Channels

Delete	Contact Channel	Contact details	Primary	Comments	Edit
	eMail (Personal)	applicant@gmail.com	Yes	-	
	Address (Home)	Somewhere, Else, ACT, AUSTRALIA	Yes	-	
	Address (Intended)	298 West 33rd Street, New York, NY 10001, USA	No	-	

Paperwork Reduction Act statement

Public reporting burden for this collection of information is estimated to average 60 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: PRA\_BurdenComments@state.gov

Confidentiality statement

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- 106 Mental Health report ○

Record Medical History (Past or present)

General

Illness or injury requiring hospitalization (including psychiatric)

Not selected No Yes

Cardiology

Hypertension

Not selected No Yes

Congestive heart failure or coronary artery disease

Not selected No Yes

Arrhythmia

Not selected No Yes

Rheumatic heart disease

Not selected No Yes

Congenital heart disease

Not selected No Yes

Pulmonology

Current Tobacco use

Not selected No Yes

Former Tobacco use

Not selected No Yes

Asthma

Not selected No Yes

Chronic obstructive pulmonary disease

Not selected No Yes

History of Tuberculosis

Not selected No Yes

Diagnosed (mm-yyyy)

Treatment

Not selected Completed On-going Not started

Treatment completed (mm-yyyy)

Fever

Not selected No Yes

Cough

Not selected No Yes

Night sweats

Not selected No Yes

Weight loss

Not selected No Yes

Signs or symptoms of TB

Not selected No Yes

Contact's Name

Contact's case or Alien number, if known

Applicant's relationship to Contact

Provide details

Date contact ended

Type of source case TB

Psychiatry

Psychological/Psychiatric Disorder (including major depression, bipolar disorder or schizophrenia)

Not selected No Yes

Major impairment in learning, intelligence, self-care, memory or communication

Not selected No Yes

Use of substances other than those required for medical reasons

Not selected No Yes

Substance use or substance induced disorders of substances on the Controlled Substances Act (CSA)

Not selected No Yes

Substance use or substance induced disorders of substances not on the CSA (including alcohol)

Not selected No Yes

Ever caused serious injury to others, caused major property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs

Not selected No Yes

Ever had thoughts of harming yourself

Not selected No Yes

Ever acted on those thoughts

Not selected No Yes

Ever had thoughts of harming others

Not selected No Yes

Ever acted on those thoughts

Neurology

History of stroke

Not selected No Yes

Seizure disorder

Not selected No Yes

Obstetrics

Is the client pregnant?

Not selected No Yes

When does the client expect to give birth?

LMP

Fundal Height (in cm)

Previous live births:

Birth dates:

Sexually Transmitted Diseases

Syphilis

Not selected No Yes

Previous treatment for Syphilis

Table with columns: Treatment, Medication, Start, End, Dose, Frequency, Side effects

Gonorrhea

Not selected No Yes

Previous treatment for Gonorrhea

Table with columns: Treatment, Medication, Start, End, Dose, Frequency, Side effects

Endocrinology

Diabetes

Not selected No Yes

Thyroid disease

Not selected No Yes

Hematologic/Lymphatic

Anemia

Not selected No Yes

Sickle Cell Disease

Not selected No Yes

Thalassemia

Not selected No Yes

Other hemoglobinopathy

Not selected No Yes

Hansen's Disease

Previous treatment

Not selected No Yes

Treatment completed (mm-yyyy)

Current diagnosis or treatment

Not selected No Yes

Other

An abnormal or reactive HIV blood test

Not selected No Yes

Diagnosed (mm-yyyy)

Malignancy

Not selected No Yes

Specify

Kidney or Bladder disease

Not selected No Yes

Chronic liver disease (Including hepatitis B or C)

Not selected No Yes

Other medical conditions requiring treatment

Not selected No Yes

Specify

Disabilities (including loss of arms or legs)

Not selected No Yes

Specify

Current medications (List all current medications)

Previous surgeries (List all previous surgeries)

Doctor declaration

Applicant appears to be providing unreliable or false information

Not selected No Yes

Specify

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501 Medical Examination: Basic questions

Basic Questions

Exam date

Height and Weight

Height   
In centimeters

Weight   
In kilograms

BMI

Blood Pressure

Initial blood pressure

Systolic

Diastolic

Pulse

Vital signs

Temperature   
In °C

Respiratory rate   
/ min

Eyes

Visual acuity testing  Not selected  Uncorrected only  Corrected only  Both  No (applicant under 15)

Uncorrected

Left eye:

Right eye:

Corrected

Left eye:

Right eye:

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## 501 Medical Examination: Detailed questions

### All systems

General appearance

\*  Not selected  Normal  Abnormal

Nutritional status (including acute wasting and or chronic stunting malnutrition)

\*  Not selected  Normal  Abnormal

Heart (S1, S2, murmur, rub)

\*  Not selected  Normal  Abnormal

Provide details

Lungs

\*  Not selected  Normal  Abnormal

Nervous system: Sequelae of stroke or cerebral palsy, other neurological disabilities

\*  Not selected  Normal  Abnormal

Abdomen (including liver, spleen)

\*  Not selected  Normal  Abnormal

Musculoskeletal system (including gait)

\*  Not selected  Normal  Abnormal

Extremities (including pulses, edema)

\*  Not selected  Normal  Abnormal

Hematologic

\*  Not selected  Normal  Abnormal

### Brain and cognition

Mental status: level of consciousness, mood, intelligence, perception, thought processes, and behavior during examination

\*  Not selected  Normal  Abnormal

### Eyes, ears, nose, throat and mouth

Eyes

\*  Not selected  Normal  Abnormal

Nose, mouth and throat (include dental)

\*  Not selected  Normal  Abnormal

Hearing and ears

\*  Not selected  Normal  Abnormal

### Miscellaneous

Skin

\*  Not selected  Normal  Abnormal

Lymph nodes

\*  Not selected  Normal  Abnormal

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501 Medical Examination: Classification and Examiner Declaration

Provide Classification

Please complete the 501 Medical Examination. If you have completed the exam and you are ready to provide the Classification, press the 'Prepare for Classification' button

Prepare for classification

Classification

Class A Conditions

- Tuberculosis disease (1A1)
Syphilis, untreated (1A1)
Gonorrhea, untreated (1A1)
Hansen's Disease, untreated multibacillary or paucibacillary (1A1)
Any physical or mental disorder (excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder) with harmful behavior or history of such behavior likely to recur (1A3)
Addiction or abuse of specific substance on the Controlled Substances Act (1A4)
Immigrant visa applicant refuses vaccinations (1A2)

Class B Conditions

Tuberculosis

- B1 TB, Pulmonary
B1 TB, Extrapulmonary

Anatomic site of disease
Treatment: Not selected, No, Current, Started but not finished, Completed

B2 TB: LTBI evaluation

LTBI treatment: Not selected, No, Current, Started but did not finish, Completed
Treated by Panel Physician: Not selected, No, Yes
LTBI regimen: Select an Option
Details
Treatment started
Treatment ended

B3 TB: Contact Evaluation

Preventative treatment: Not selected, No, Window prophylaxis
Prophylaxis Regime: Select an Option
Details
Treatment started
Treatment ended

- Syphilis, treated within last year
Gonorrhea, treated within last year

Hansen's Disease

- Treated multibacillary
Treated paucibacillary

- Any physical or mental disorder (excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur
Sustained, full remission of addiction or abuse of specific substance on the Controlled Substances Act

Class B Other

Details: Mandatory if ticked

No apparent defect, disease or disability

If you wish to update the examination answers then press the 'Edit exam' button.

Edit exam

Examiner declaration

I attest that I performed this examination, have reviewed all test results, and that the medical classification is correct in accordance with the Centers for Disease Control and Prevention's Technical Instructions for panel physicians. I further attest that I have a current panel physician agreement with the Department of State.

Completed by: <Doctor's name>
Date of declaration: <Today's date>

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## Provide Classification

Please complete the 501 Medical Examination. If you have completed the exam and you are ready to provide the Classification, press the 'Prepare for Classification' button

Prepare for classification

### Classification

#### Class A Conditions

- Tuberculosis disease (1A1)
- Syphilis, untreated (1A1)
- Gonorrhea, untreated (1A1)
- Hansen's Disease, untreated multibacillary or paucibacillary (1A1)
- Any physical or mental disorder (*excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder*) with harmful behavior or history of such behavior likely to recur (1A3)
- Addiction or abuse of specific substance on the Controlled Substances Act (1A4)
- Immigrant visa applicant refuses vaccinations (1A2)

#### Class B Conditions

##### Tuberculosis

- B1 TB, Pulmonary
- B1 TB, Extrapulmonary
- B2 TB: LTBI evaluation
- B3 TB: Contact Evaluation

- Syphilis, treated within last year
- Gonorrhea, treated within last year

##### Hansen's Disease

- Treated multibacillary
- Treated paucibacillary

- Any physical or mental disorder (*excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder*) without harmful behavior or history of such behavior unlikely to recur
- Sustained, full remission of addiction or abuse of specific substance on the Controlled Substances Act

#### Class B Other

#### No apparent defect, disease or disability

If you wish to update the examination answers then press the 'Edit exam' button.

Edit exam

### Examiner declaration

- I attest that I performed this examination, have reviewed all test results, and that the medical classification is correct in accordance with the Centers for Disease Control and Prevention's Technical Instructions for panel physicians.

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**Completed by** <Doctor's name>

**Date of declaration** <Today's date>

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## 502 Chest X-ray Examination: Pregnancy Declaration

Pregnancy, current

Not selected  No  Yes

Estimated delivery date (mm-dd-yyyy)

25Jun2012 

Does the client wish to proceed with the required X-ray examination(s)?

Not selected  No  Yes

### Pre exam

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## 502 Chest X-ray Examination: Attach x-ray images

### Attach x-ray images

Date of x-ray

\*



### Attachments

[Link to existing](#)



[Add new](#)



Delete	Document type	Details	Attachment type	Sending method	File name	Edit
No documents have been attached						

#### Pre exam ✔

Health case details ✔

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## 502 Chest X-ray Examination: Findings

### Record results

Exam date

\*  

Findings

\*  Not selected  Normal  Abnormal

Mark all that apply

#### Suggests Tuberculosis (*will require Smears and Cultures*)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Infiltrate or consolidation                                      | <input type="checkbox"/> Pleural effusion               | <input type="checkbox"/> Discrete nodule(s) without calcification |
| <input type="checkbox"/> Reticular markings suggestive of fibrosis                        | <input type="checkbox"/> Hilar / mediastinal adenopathy | <input type="checkbox"/> Volume loss or retraction                |
| <input type="checkbox"/> Cavitory lesion  | <input type="checkbox"/> Miliary findings               | <input type="checkbox"/> Irregular thick pleural reaction         |
| <input type="checkbox"/> Nodule or mass with poorly defined margins (such as tuberculoma) | <input type="checkbox"/> Discrete linear opacity        | <input type="checkbox"/> Other                                    |

#### Smears and Cultures not required

- |  |   |
|--|---|
| <input type="checkbox"/> Cardiac         | <input type="checkbox"/> Smooth pleural thickening (if at CPA, must confirm is not effusion [do lateral or decubitus radiograph or ultrasound]) |
| <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Diaphragmatic tenting  |
| <input type="checkbox"/> Other           | <input type="checkbox"/> Single or scattered calcified pulmonary nodule(s)  |
|  | <input type="checkbox"/> Calcified lymph node(s)  |

Remarks

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## 502 Chest X-ray Examination: Examiner Declaration

### Prepare for Declaration

<variable text according to exam status>

General supporting comments

Prepare for Declaration

Edit Exam

If you wish to update the examination answers then press the 'Edit exam' button

### Examiner declaration

I declare that this chest x-ray examination report is a true and correct record of my findings

**Completed by**

<Radiologist's name>

**Date of declaration**

<Today's date>

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Submit Exam

603 Investigation on current state of tuberculos: Record results

Confirm identity

Was the applicant's identity confirmed?  Not selected  Yes  No

Record results

Exam date

Exam description Investigation required to determine the current status regarding tuberculosis. Please include the following information:  
 -Results of 3 current smears and cultures (sputum samples taken on 3 consecutive working mornings, or other appropriate specimens as clinically indicated) and cultures for Mycobacterium tuberculosis (plus drug susceptibility testing (DST) if cultures are positive),  
 -Old chest x-rays for comparison (if available). Reports can be submitted if images available are not digital,  
 -Any previous reports regarding any treatment of tuberculosis.

Sputum Smears and Cultures

Sputum Smear Laboratory

Sputum Culture Laboratory

Specimen obtained	Test date	Test name	Result	Remarks
<dd Mmm yyyy>	<dd Mmm yyyy>	Sputum Smear	Positive	-
<dd Mmm yyyy>	<dd Mmm yyyy>	Culture	Negative	Path lab closed

Recording of Laboratory Tests is complete

Clinical diagnosis of TB?  Not selected  Yes  No

Drug susceptibility tests

Method of DST

Date specimen obtained

Date specimen reported

Drug Susceptibility Test Laboratory

Drug	Finding
Isoniazid	<Susceptible / Resistant>

Molecular tests Used in addition?  Not selected  Yes  No

Molecular Test	Test For	Finding
Hain Line Probe Assay	Isoniazid resistance	<Positive / Negative>>
Hain Line Probe Assay	Rifampin resistance	<Positive / Negative>>

Second-Line Test performed?  Not selected  Yes  No

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### Add / Edit Laboratory tests

Test name \*

Specimen obtained

Test result

Test Date

Remarks

Cancel OK

### Add / Edit DST + X

Drug \*  ?

Specify \*

Finding \*  Not selected  Susceptible  Resistant

Cancel OK

### Add / Edit Molecular test + X

Molecular test \*

Other \*

Test for \*

Finding \*  Not selected  Positive  Negative

Cancel OK

607 Continued anti-tuberculosis treatment: Record results

Confirm identity

Was the applicant's identity confirmed?  Not selected  Yes  No

Record results

Exam date

Exam Description Positive sputum smears/cultures or commencement of TB treatment advice noted with thanks. Await final report with repeat chest x-ray upon completion of TB treatment.

Treatment

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	

Treated at designated DOT site?  Not selected  No  Yes

Recording of Treatment is complete

Post-treatment Clinical diagnosis (for Radiologist to complete)

Date radiograph obtained

Findings suggestive of TB?  Not selected  No  Yes

- Findings present
- Suggests Tuberculosis
    - Infiltrate or consolidation
    - Reticular markings suggestive of fibrosis
    - Cavitory lesion
    - Nodule(s) or mass with poorly defined margins (such as tuberculoma)
    - Pleural effusion
    - Hilar / mediastinal adenopathy
    - Miliary findings
    - Discrete linear opacity
    - Discrete nodule(s) without calcification
    - Volume loss or retraction
    - Irregular thick pleural reaction
    - Other
  - Does not suggest Tuberculosis
    - Cardiac
    - Musculoskeletal
    - Other
    - Smooth pleural thickening (if at CPA, must confirm is not effusion [do lateral or decubitus radiograph or ultrasound])
    - Diaphragmatic tenting
    - Single or scattered calcified pulmonary nodule(s)
    - Calcified lymph node(s)

Remarks

Interpreted by <Radiologist's name>

Date radiograph interpreted

I declare that these are a true and correct record of my findings

Sputum Smears and Cultures

Sputum Smear Laboratory

Sputum Culture Laboratory

Specimen obtained	Test date	Test name	Result	Remarks
<dd Mmm yyyy>	<dd Mmm yyyy>	Sputum Smear	Positive	-
<dd Mmm yyyy>	<dd Mmm yyyy>	Culture	Negative	Path lab closed

Recording of Laboratory Tests is complete

Clinical diagnosis of TB?  Not selected  Yes  No

Drug susceptibility tests

Method of DST

Date specimen obtained

Date specimen reported

Drug Susceptibility Test Laboratory

Drug	Result
Isoniazid	<Susceptible / Resistant>

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## 712 Syphilis test (VDRL or RPR): Record results

### Confirm identity

Was the applicant's identity confirmed? \*  Not selected  Yes  No

### Record results

Exam date \*  

Exam description Syphilis testing and results are required

### Screening

Test name \*

Date specimen reported \*  

Syphilis test result \*  Not selected  Non-reactive  Reactive

Titer \*

### Confirmatory

Test name \*

Date specimen reported \*  

Repeat Syphilis test result \*  Not selected  Non-reactive  Reactive

Clinical judgment on result \*  Not selected  Treatment warranted  Previous treatment, no new risk factors since treatment

Stage of Syphilis \*  

Applicant elects to undergo treatment? \*  Not selected  No  Yes

### Treatment

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	 

By Panel Physician? \*  Not selected  No  Yes  
 Recording of Treatment is complete

### Attachments

General Supporting Comments

## 713 Gonorrhea: Record results

### Confirm identity

Was the applicant's identity confirmed? \*  Not selected  Yes  No

### Record results

Exam Date \*  

Exam description Record testing and treatment for Gonorrhea

Was laboratory testing performed \*  Not selected  No  Yes

### Screening



Date specimen reported \*  

Test name \*

Gonorrhea test result \*  Not selected  Positive  Negative

Applicant elects to undergo treatment? \*  Not selected  No  Yes

### Treatment

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	 

Recording of Treatment is complete

### Attachments

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## 714 Hansen's Disease: Record results

### Confirm identity ?

Was the applicant's identity confirmed?  Not selected  Yes  No

### Record results ?

Exam Date \*  

Exam description Record diagnosis and treatment for Hansen's Disease

### Initial Diagnosis

Made by \*  Not selected  Panel Physician  Non-panel physician prior to current evaluation

Year of diagnosis \*

Type of Hansen's disease \*  Not selected  Multibacillary  Paucibacillary



### Treatment

Treatment \*  Not selected  None  Partial ( ≥7 days)  Completed

Treated by panel physician? \*  Not selected  No  Yes

Referred for treatment? \*  Not selected  No  Yes

Referral facility \*

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	 

### Attachments

General Supporting Comments

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- Detailed questions ○
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- Pregnancy declaration ○
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- 714 Hansen's Disease ○
- 719 TB screening test – TST or IGRA ○
- 951 Vaccinations ○
- 106 Mental Health report ○



## 719 TB screening test - TST or IGRA: Record results

### Confirm identity

Was the applicant's identity confirmed?  Not selected  Yes  No

### Record results

Exam Date (date drawn/applied) \*

20Jun2015

Exam description

Provide current results of tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA).

Type of exam conducted

Not selected  Tuberculin Skin Test (TST)  Interferon Gamma Release Assay (IGRA)

Date of Reading \*

27Jun2015

Millimetres of induration \*

Type of IGRA test

Select an Option

Result

Not selected  Negative  Indeterminate, Borderline or Equivocal  Positive

Provide details

General supporting comments

### Attachments

[Link to existing](#)

[Add new](#)

Delete	Document type	Details	Attachment type	Sending method	File name	Edit
No documents have been attached						

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## 106 Mental Health report: Record results

### Confirm identity

Was the applicant's identity confirmed? \*  Not selected  Yes  No

### Record results

Exam date \*  

Exam description

**Mental health questions must be answered by panel physician. If applicant is referred to a mental health specialist for further evaluation, panel physician must attach report.**

Any physical or mental disorder (excluding addiction or abuse of specific substance on the Controlled Substances Act, but including other substance-related disorder) \*

Not selected  No  Yes

With harmful behavior present or likely to recur? \*

Not selected  No  Yes

Details of disorder \*

Without harmful behavior present and unlikely to recur? \*

Not selected  No  Yes

Details of disorder \*

Addiction or abuse of specific substance on the Controlled Substances Act \*

Not selected  No  Yes

Current addiction or abuse? \*

Not selected  No  Yes

Details of substances \*

Sustained, full remission? \*

Not selected  No  Yes

Details of substances \*

### Attachments

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## 951 Vaccination: Record results

### Confirm identity

Was the applicant's identity confirmed? \*  Not selected  Yes  No

### Record results

Exam date \*  

Exam Description Applicant's full vaccination history is required

Disease	Vaccine	Vaccination history	Administered by clinic	Immunity Positive	History	Waiver reasons
<Disease name>	<Vaccine name>	dd Mmm yyyy dd Mmm yyyy dd Mmm yyyy	dd Mmm yyyy dd Mmm yyyy dd Mmm yyyy	dd Mmm yyyy	Yes	Contra-indicated Flu Vaccine not available  

### Vaccination Documentation

Vaccination requirements complete? \*  Not selected  No  Yes 

Reason \*

- Refugee, follow to join Asylee/Refugee (V92/93) applicant not required to meet vaccination requirements
- K-Visa applicant electing to not be vaccinated at this examination
- Other NIV applicant not required to meet vaccination requirements
- Immigrant Visa or Parolee applicant completed vaccination requirements
- K Visa applicant voluntarily completed vaccination requirements




























Contra-indications

- Current Pregnancy
- Immune compromised
- History of severe allergic reaction to vaccine or vaccine component
- Other severe reaction to vaccine
- Current moderate to severe illness
- Other


Other Contra-indication \*

Remarks

### Attachments

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## Add / Edit Vaccination

Disease \* Diphtheria, Tetanus, Pertussis, Hib, Hepatitis B, Polio 

Vaccine \* Hexavalent 


### Vaccination history (given elsewhere)

Date(s) given

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	

### Vaccination given by panel site

Date(s) given

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	

### Test for Immunity Positive

Date  

### History of disease

Has the applicant had the disease? \*  Not selected  Yes  No

### Blanket waiver

- Waiver reason(s)
- Not age appropriate
  - Insufficient time interval to complete series
  - Contra-indicated
  - Not routinely available
  - Flu vaccine not available
  - Known chronic hepatitis B virus infection



Cancel

OK