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| **Medical Complaint Form**  **Unaccompanied Children’s Program**  **Office of Refugee Resettlement (ORR)** | | | | | | | | | | | | | | | | | | | |
| **General Information** (to be completed by program staff) | | | | | | | | | | | | | | | | | | | |
| **Child** | Last name: | | | | | | | | | | | First name: | | | | | | | |
| DOB: | | | | | | A#: | | | | | | | | | Gender: | | | |
| **Healthcare Provider** | Name:  **MD / DO / PA / NP** | | | | | | | | | Phone number: | | | | | Clinic or Practice: | | | | |
| Street address: | | | | | | | | | City or Town: | | | | | State: | | Date evaluated: | | |
| Location where child received care  (e.g., onsite, offsite, ER, Admitted to hospital): | | | | | | | |  | | | | | | | | | | |
| **Program** | Name of program staff with child: | | | | | | | | | | | | Program name: | | | | | | |
| **Reason for medical visit (e.g., asthma, immunizations, fever, injury):** | | | | | | | | | | | | | | | | | | | |
| **History and Physical Exam** (to be completed by healthcare provider) | | | | | | | | | | | | | | | | | | | |
| **Vital Signs** | | | | | | | | | | | | | | | | | | | |
| T (Co): | | BP (> 3 years): | | | | HR: | | | | | RR: | | | Ht (cm): | | | | Wt (kg): | |
| **History of present illness / condition:** | | | | | | | | | | | | | | | | | | | |
| **Allergies to medications:** | | | * No | * Yes, **specify:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Review of Systems (ROS):** Check all applicable signs and symptoms and enter the date each began. | | | | | | | | | | | | | | | | | | | |
| * No abnormal findings | | | | |  | | | * Pain, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Fever (>37.8 Co) or chills | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Red eyes | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Runny nose | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Sore throat | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Cough | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Difficulty breathing/Shortness of breath/Wheezing | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Nausea | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Vomiting | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Diarrhea | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Neck stiffness | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Headache | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Confusion/Altered mental status | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Dizziness | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Neurologic symptoms | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Skin lesions or rash | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Yellow skin or eyes | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Swollen glands | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ | | | * Unusual bleeding | | | | | | | | | | | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Other 1, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_\_/\_\_\_\_ * Other 2, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_\_/\_\_\_\_ * Other 3, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Exam Findings:** | | | | | | | | | | | | | | | | | | | |

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| **Assessment / Diagnosis and Plan** | | | | | |
| **Assessment/ Diagnosis:** | Child without new complaints, symptoms, diagnoses/conditions; no prescription meds or referrals needed: | | | * No | * Yes |
| If No, check all diagnoses that apply. If “Other” is selected, specify in the space provided. | | | | |
| **General / Constitutional**   |  |  | | --- | --- | | * Allergy (e.g., drug reaction, food allergy),   specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | * Dehydration | * Malnourished | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **HEENT**   |  |  | | --- | --- | | * Headache/Migraine | * Hearing issues | | * Otitis media/Ear infection | * Pharyngitis (Not strep throat) | | * Rhinitis | * Strep throat | | * Vision issues | * Viral/Bacterial Conjunctivitis | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Respiratory / Pulmonary**   |  |  | | --- | --- | | * Asthma | * Influenza-like illness (ILI) | | * Influenza, lab-confirmed; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | * Upper/lower respiratory illness; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Cardiovascular**   |  |  | | --- | --- | | * Heart murmur | * Syncope/fainting | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Gastrointestinal**   |  |  | | --- | --- | | * Abdominal pain | * Gastroenteritis | | * Heartburn/reflux | * Intestinal parasites | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Genito-urinary / Reproductive**   |  |  | | --- | --- | | * Childbirth | * Elective abortion | | * Genital warts | * Pregnancy/Pregnancy-related | | * Spontaneous abortion | * Urinary tract infection | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **Neurological**   |  |  | | --- | --- | | * Developmental delay | * Seizure/epilepsy | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |     **Skin, Hair, and Nails**   |  |  | | --- | --- | | * Cellulitis | * Dermatitis/Rash (not acne) | | * Ingrown toenail | * Lice | | * Scabies | * Tinea pedis | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Musculoskeletal**   |  |  | | --- | --- | | * Back pain | * Fracture | | * Leg pain | * Sprain/Strain | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Potentially Reportable Infectious Disease**   |  |  | | --- | --- | | * Acute hepatitis A | * Acute/chronic hepatitis B | | * Acute/chronic hepatitis C | * Chikungunya | | * Chlamydia | * Dengue | | * Gonorrhea | * HIV | | * Malaria | * Measles | | * Mumps | * Pertussis | | * Rubella | * Sepsis/Meningitis | | * Syphilis | * TB | | * Typhoid fever | * Varicella | | * Viral hemorrhagic fever, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Zika virus | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Abuse**   |  |  | | --- | --- | | * Sexual | * Physical | | * Other 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  * **Other, Medical:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Plan:** Specify in the space provided (e.g., labs ordered, referrals, medications, immunizations) | | | | | |
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| **Child quarantined/isolated at the program for a diagnosis:** | | * No | * Yes, **specify**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Release of child from the program delayed because of a diagnosis:** | | * No | * Yes, **specify**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Recommendations from healthcare provider:** | | | | | |
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| **Potentially Reportable Infectious Diseases** | | | |
| **Lab testing performed to confirm the diagnosis:** | * No | * Yes | |
| **Health department notified by program:** | * No | * Yes | * Not applicable |
| **Intakes delayed/postponed because of this diagnosis:** | * No | * Yes | |
| **UC exposed to this child while infectious:** | * No | * Yes (enter a Contact Investigation Form for each exposed UC) | |
| **Number of staff members exposed to this diagnosis:** |  | | |

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| **Potentially Reportable Infectious Disease (Non-TB) Lab Testing** | | | | |
| **Disease Tested** | **Collection Date** | **Specimen Type (e.g., Serum)** | **Test Type (e.g., IgM)** | **Result** |
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| **Bacteriologic Results (TB)** | | | | | | |
| **Collection Date** | **Specimen Type (e.g., Sputum)** | | **Test Type (e.g., AFB smear)** | | | **Result** |
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| **Special Requirements for Release** | | | | | | |
| **If the child had been AFB smear positive, list the dates of the**  **3 consecutive negative AFB smears:** | | #1: | | #2: | #3: | |
| **If the TB culture was positive and the DST was MDR or XDR,**  **list the dates of the 2 subsequent negative cultures:** | | #1: | | #2: | | |

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