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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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|  |
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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) |
|  |
| **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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