OMB Control No: 0970-XXXX
Expiration date: XX/XX/XXXX

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 (C°):	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 C°) 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)

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:

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:			

Potentially Reportable Infectious Disease (Non-TB) Lab Testing				
Disease Tested	**Collection Date**	**Specimen Type (e.g., Serum)**	**Test Type (e.g., IgM)**	**Result**

Bacteriologic Results (TB)			
Collection Date	**Specimen Type (e.g., Sputum)**	**Test Type (e.g., AFB smear)**	**Result**

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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