|  |
| --- |
| **Initial Medical Exam** **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 of visit:  |
| **Program**  | Name of program staff with child: | Program name: |
| **History and Physical** (to be completed by healthcare provider) |
| **Vital Signs** |
| T (Co):  | HR: | BP (> 3 years): | RR:  | Ht (cm):  | Wt (kg):  |
|  **Allergies** | * Check if none
 |
| * Food, specify:
 | * Medication, specify:
 | * Other, specify:
 |
| **Vision** (> 5 years) |
|  | **Right Eye** | **Left Eye** | **Both eyes** |
| Corrected | 20 / | 20 / | 20 / |
| Uncorrected | 20 / | 20 / | 20 / |
| **Medical History** |
| Concerns expressed by child or caregiver: | * No concerns
 |
| Past medical history (include surgeries and hospital admissions):  |
| Family History: |
| Reproductive History:   | LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ or  | * N/A
 | Previous pregnancy: G \_\_\_\_\_\_\_ P \_\_\_\_\_\_\_ or  | * N/A
 |
| **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: \_\_\_/\_\_\_\_/\_\_\_\_
 |

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|  |
| --- |
| **Physical Examination** |
| **Check each system to indicate if normal or abnormal and describe. Leave blank if not evaluated:** |
| **System** | **Normal** | **Abnormal** | **Describe** |
| General appearance |  |  |  |
| HEENT |  |  |  |
| Neck |  |  |  |
| Heart |  |  |  |
| Lungs |  |  |  |
| GU/GYN |  |  |  |
| Extremities |  |  |  |
| Abdomen |  |  |  |
| Back/Spine |  |  |  |
| Neurologic |  |  |  |
| Skin (include tattoos) |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| **Psychosocial Risk**  |
| **In each section, place a check next to each reported condition**/**history/behavior & describe where applicable:** |
|  **Mental Health** (Over the past 3 months) | * Check if no concerns
 |
| * Feels empty, hopeless, sad, numb more often than not
 | * Has trouble concentrating, restless, too many thoughts
 |
| * Feels constantly worried, anxious, nervous more often than not
 | * Has trouble eating, sleeping
 |
| * Experiences mood swings, from very high to very low
 | * Feels helpless
 |
| * Relives traumatic events from the past
 | * Feels like hurting others
 |
| * Feels easily annoyed or irritated
 | * Feels like hurting self, would be better off dead
 |
| * Feels afraid, easily startled, jumpy
 | * Other concerns:
 |
| **Physical Abuse History** | * Check if physical abuse is denied
 |
| * Victim of physical abuse, specify who/when/where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * In home country
 | * During journey to U.S.
 |
| * In US, not in ORR custody
 | * In ORR custody
 |
| **Sexual Activity/Abuse History** | * Check if sexual activity or abuse are denied
 |
| * Consensual sexual activity (oral/vaginal/anal)
 |
| * Sexual abuse, specify who/when/where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | * In home country
 | * During journey to U.S.
 |
| * In US, not in ORR custody
 | * In ORR custody
 |
| * Previous STD diagnosis, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  **Substance Use** | * Check if substance use is denied
 |
| * IVDU:
 | * Alcohol:
 | * Tobacco:
 | * Other:
 |
| **Laboratory Testing** |
| **Ordered** | **Test** | **Indicators** | **Result** |
| **Positive** | **Negative** | **Indeterminate** |
|  | Flu, rapid | Fever + cough or sore throat |  |  |  |
|  | HIV  | > 13 yrs or Sexual activity/abuse |  |  |  |
|  | Pregnancy  | >10 yrs or Sexual activity/abuse |  |  |  |
|  | Lead **(positive >5** **mcg/dl)** | 6 mos - 6 yrs |  |  |  |
|  | Hepatitis B surface antigen | Sexual activity/IVDU  |  |  |  |
|  | Hepatitis C antibody | IVDU |  |  |  |
|  | Syphilis RPR/VRDL | Sexual activity/abuse |  |  |  |
|  | Chlamydia NAAT | Sexual activity/abuse |  |  |  |
|  | Gonorrhea NAAT | Sexual activity/abuse |  |  |  |
|  **TB Screening** (Use Supplemental TB Screening form for result documentation) |
| Has child ever been a close contact to someone with ***active*** TB disease? | * No
 | * Yes, specify:
 |
| Has child ever been treated for ***active*** TB disease? | * No
 | * Yes, specify:
 |
| Has child ever been treated for ***latent*** TB infection? | * No
 | * Yes, specify:
 |
| **TB screening method ordered:** | * TST
 | * IGRA
 | * CXR
 | * Was or will be tested elsewhere
 |

|  |
| --- |
| **Assessment and Plan** |
| **Assessment:**   | Child without complaints, symptoms, diagnoses/conditions; no meds (including OTC) 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**HEENT**

|  |  |
| --- | --- |
| * Headache/Migraine
 | * Hearing issues
 |
| * Otitis media/Ear infection
 | * Pharyngitis (Not strep throat)
 |
| * Rhinitis
 | * Strep throat
 |
| * Vision issues
 | * Viral/Bacterial Conjunctivitis
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |

**Respiratory/Pulmonary**

|  |  |
| --- | --- |
| * Asthma
 | * Influenza-like illness (ILI)
 |
| * Influenza, lab-confirmed; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Upper/lower respiratory illness; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Cardiovascular**

|  |  |
| --- | --- |
| * Heart murmur
 | * Syncope/fainting
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Gastrointestinal**

|  |  |
| --- | --- |
| * Abdominal pain
 | * Gastroenteritis
 |
| * Heartburn/reflux
 | * Intestinal parasites
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Genito-urinary/Reproductive**

|  |  |
| --- | --- |
| * Childbirth
 | * Pregnancy/Pregnancy-related
 |
| * Genital warts
 | * Urinary tract infection
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Neurological**

|  |  |
| --- | --- |
| * Developmental delay
 | * Seizure/epilepsy
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal**

|  |  |
| --- | --- |
| * Back pain
 | * Fracture
 |
| * Leg pain
 | * Sprain/Strain
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

 |

 | **Skin, Hair, and Nails**

|  |  |
| --- | --- |
| * Cellulitis
 | * Dermatitis/Rash (not acne)
 |
| * Ingrown toenail
 | * Lice
 |
| * Scabies
 | * Tinea pedis
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Abuse**

|  |
| --- |
| * Sexual; where/when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Physical; where/when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

* **Other, Medical:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Behavioral and Mental Health Concerns**

|  |  |
| --- | --- |
| * ADHD/ADD
 | * Adjustment disorder
 |
| * Anxiety disorder
 | * Bipolar disorder
 |
| * Borderline personality disorder
 | * Depressive disorder
 |
| * Panic disorder
 | * PTSD
 |
| * Schizophrenia
 | * Self-injury/cutting
 |
| * Suicide ideation/attempt
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

 |
| **Plan:** Check all that apply and specify in the space provided. |
| Return to clinic:* PRN/As needed
 | * Follow-up (specify condition, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Referred to specialist/counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Prolonged treatment/therapy (e.g., physical therapy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * New/Current medications (specify name, reason, date started, dose, and directions and indicate if psychotropic):
 |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Immunizations given/validated from foreign record
* List immunizations not given due to medical contraindication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Age-appropriate anticipatory guidance discussed and/or handout given
 |
| * Child quarantined/isolated at the program for a diagnosis, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Release of child delayed from the program because of a diagnosis, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Additional Information** |
|  |

|  |
| --- |
| **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
 |
| UAC exposed to this child while infectious: | * No
 | * Yes (Complete a Contact Investigation Form for each exposed UAC)
 |
| 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** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please provide copies of office notes, lab/imaging results, and immunization records to program staff.

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