

## Initial Medical Exam Unaccompanied Children's Program Office of Refugee Resettlement (ORR)

### General Information (to be completed by program staff)

<b>Child</b>	Last name:	First name:		
	DOB:	A#:	Gender:	
<b>Healthcare Provider</b>	Name: <span style="float: right;">MD / DO / PA / NP</span>	Phone number:	Clinic or Practice:	
	Street address:	City or Town:	State:	Date of visit:
<b>Program</b>	Name of program staff with child:		Program name:	

### History and Physical (to be completed by healthcare provider)

#### Vital Signs

T (C°):	HR:	BP (≥ 3 years):	RR:	Ht (cm):	Wt (kg):
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#### Allergies € Check if none

€ Food, specify:	€ Medication, specify:	€ Other, specify:
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#### 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:

Travel history (countries visited, dates of arrival and departure for each):

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 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:		___/___/___

**Physical Examination**

Check each system to indicate if normal or abnormal and describe. Leave blank if not evaluated:

System	Normal	Abnormal	Describe
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
GU/GYN	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Back/Spine	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	
Skin (include tattoos)	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	

**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
- Feels constantly worried, anxious, nervous more often than not
- Experiences mood swings, from very high to very low
- Relives traumatic events from the past
- Feels easily annoyed or irritated
- Feels afraid, easily startled, jumpy
- Has trouble concentrating, restless, too many thoughts
- Has trouble eating, sleeping
- Feels helpless
- Feels like hurting others
- Feels like hurting self, would be better off dead
- 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
- 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
- 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
<input type="checkbox"/>	Flu, rapid	Fever + cough or sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	HIV	≥ 13 yrs or Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Pregnancy	≥10 yrs or Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Lead (positive ≥5 mcg/dl)	6 mos up to 6 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis B surface antigen	Sexual activity/IVDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis C antibody	IVDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Syphilis RPR/VRDL	Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Chlamydia NAAT	Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Gonorrhea NAAT	Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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 ac)
- Ingrown toenail  Lice
- Scabies  Tinea pedis
- Other: \_\_\_\_\_

**Potentially Reportable Infectious Disease**

- Acute hepatitis A  Acute/chronic hepatitis B
- Acute/chronic hepatitis C  Chikungunya
- Chlamydia  COVID-19
- Dengue  Gonorrhea
- HIV  Malaria
- Measles  Mumps
- Pertussis  Rubella
- Sepsis/Meningitis  Syphilis
- TB  Typhoid fever
- Varicella  Zika virus
- Viral hemorrhagic fever, specify: \_\_\_\_\_
- Other: \_\_\_\_\_

**Abuse**

- Sexual  Physical
- 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: \_\_\_\_\_  
 \_\_\_\_\_

**Potentially Reportable Infectious Diseases**

Specify the reportable infectious disease diagnosed:

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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