OMB Control No: 0970-0509
Expiration date: 05/31/2021

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/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 (check all that apply):

€ Follow-up immunizations €Follow-up visit/referral for known condition, specify, ___________________________________

€ Routine well-child check €New onset symptoms/complaint

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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Diagnosis and Plan

Diagnosis: If child was seen for signs/symptoms/complaints, check all diagnoses that apply. If the diagnosis is not listed, check "Other" and 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
- € COVID-19
- € Dengue
- € Gonorrhea
- € HIV
- € Malaria
- € Measles
- € Mumps
- € Pertussis
- € Rubella
- € Sepsis/Meningitis
- € Syphilis
- € TB
- € Typhoid fever
- € Varicella
- € Zika virus
- € Viral hemorrhagic fever, specify: __________
- € Other 1: ____________________
- € Other 2: ____________________

Abuse
- € Sexual; where/when: ____________________
- € Physical
- € Other 1: ____________________
- € Other 2: ____________________

€ **Other, Medical:** ____________________

Plan; specify (e.g., labs/imaging studies 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			
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**

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:	

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

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