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| **Initial Medical Exam Form**  **Unaccompanied Children’s Program**  **Office of Refugee Resettlement (ORR)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Minor** | | | | Last name: | | | | | | | | | | | | | | | | | | | | First name: | | | | | | | | | | | | | | | |
| DOB: | | | | | | | | | | | | | | | | | A#: | | | | | | | | | | Gender: | | | | | | | | |
| **Healthcare Provider (HCP)** | | | | Name:  **MD / DO / PA / NP** | | | | | | | | | | | | | | | | | Phone number: | | | | | | | | Clinic or Practice: | | | | | | | | | | |
| Street address: | | | | | | | | | | | | | | | | | City or Town: | | | | | | | | State: | | | | | | | Date evaluated: | | | |
| **Program** | | | | Program name: | | | | | | | | | | | | | | | | | | | | | * Program Staff Member Present During Exam with HCP | | | | | | | | | | | | | | |
| **History and Physical Assessment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vital Signs** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Temperature (T)** | | | | | **Heart Rate (HR)** | | | **BP (> 3 yrs)** | | | | | | | | | **Resp Rate (RR)** | | | | | | **Height (HT)** | | | | **Weight (WT)** | | | | | | **BMI (>2 yrs)** | | | | | **BMI %ile** | |
| F / C | | | | |  | | |  | | | | | | | | |  | | | | | | in / cm | | | | lbs / kg | | | | | |  | | | | |  | |
| **Allergies:** | | * No | | | | * Yes, specify below | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Food** | | | | | | | | | | | | **Medication** | | | | | | | | | | | **Environmental** | | | | | | | | | | **Other** | | | | | |
| Allergen |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Reaction |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| **Vision Screening** (> 3 years): | | | | | | | * No | | * Yes, specify below | | | | | | | | | | | | | | | **Hearing Screening:** | | | | * No | | | | * Yes, specify below | | | | | | | |
|  | | | | **Right Eye** | | | **Left Eye** | | | | | **Both eyes** | | | | | **Final** | | | | | | | OAE/ABR | | | | | | | | | | | * Pass | | | | * Fail |
| Corrected | | | | 20 / | | | 20 / | | | | | 20 / | | | | | * Pass | | | * Fail | | | | Gross Hearing (< 4 Years) | | | | | | | | | | | * Pass | | | | * Fail |
| Uncorrected | | | | 20 / | | | 20 / | | | | | 20 / | | | | | * Pass | | | * Fail | | | | Pure Tone Audiometry (>= 4 Years) Result | | | | | | | | | | | * Pass | | | | * Fail |
| **Medical History** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Concerns expressed by child or caregiver: | | | | | | | | | | | * No | | | | * Yes, specify: | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Past medical history (include surgeries and hospital admissions): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Was healthcare received in DHS custody? | | | | | | | | | | * No | | | | * Yes, specify: | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social/Family History: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Travel history (countries visited, dates of arrival and departure for each): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reproductive History: | | | * Menarche: Date of LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_, if unknown, months since LMP: \_\_\_\_\_\_; | | | | | | | | | | | | | | | | | | | | | | | | | | | * Pregnancy: Gravida \_\_\_\_\_\_ Parity \_\_\_\_\_\_ | | | | | | | | | |
| * N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Review of Systems (ROS) and Physical Exam** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Were any signs/symptoms reported by the minor or observed by program staff or HCP?** | | | | | | | | | | | | | | | | | | * No | * Yes, check all applicable signs/symptoms and enter the onset date (mm/dd/yyyy): | | | | | | | | | | | | | | | | | | | | |
| **Sign/Symptom** | | | | | * **Pain, location:**   **\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | * **Fever (>37.8 Co) or chills** | | | | | | | | * **Red Eyes** | | | | | | * **Runny Nose** | | | | * **Sore Throat** | | | | | * **Cough** | | | | | | * **Difficulty breathing/ Shortness of Breath** | | |
| **Onset Date** | | | | |  | | |  | | | | | | | |  | | | | | |  | | | |  | | | | |  | | | | | |  | | |
| **Sign/Symptom** | | | | | * **Nausea** | | | * **Vomiting** | | | | | | | | * **Diarrhea** | | | | | | * **Neck stiffness** | | | | * **Headache** | | | | | * **Dizziness** | | | | | | * **Confusion/Altered mental status** | | |
| **Onset Date** | | | | |  | | |  | | | | | | | |  | | | | | |  | | | |  | | | | |  | | | | | |  | | |
| **Sign/Symptom** | | | | | * **Neurologic symptoms** | | | * **Skin lesions/Rash** | | | | | | | | * **Yellow skin/eyes** | | | | | | * **Swollen glands** | | | | * **Unusual bleeding** | | | | | * **Other: \_\_\_\_\_\_\_\_\_\_\_** | | | | | | * **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Onset Date** | | | | |  | | |  | | | | | | | |  | | | | | |  | | | |  | | | | |  | | | | | |  | | |

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| **Physical Examination** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **System** | | | | | **Not eval** | **Evaluated, Findings** | | | | | | | **Describe or if not evaluated, provide reason** | | | | | | | | | | | | | | | | |
| General appearance | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| HEENT | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Neck | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Heart | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Lungs | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| GU/GYN | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Extremities | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Abdomen | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Back/Spine | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Neurologic | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Skin (include tattoos) | | | | |  | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | * Normal | | | * Abnormal | | | |  | | | | | | | | | | | | | | | | |
| **Psychosocial Risk** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mental Health Concerns** (< 3 mos) | | | | * Yes, specify below | | | * Denied, with no obvious signs/symptoms | | | | | | * Denied, but obvious signs/symptoms present | | | | | * Unable to obtain/report response, specify reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| * 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Is minor able to attribute these feelings to a specific reason(s)? | | | | | | | | | | | | * No | | * Yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Physical Abuse History** | | | * Yes, specify below | | | * Denied, with no obvious signs/symptoms | | | | | | | * Denied, but obvious signs/symptoms present | | | | | * Unable to obtain/report response, specify reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Specify who/when/where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Part/All of abuse related to gang violence | | | | | | | | | | | | | | | | | | * In home country | | | | | | | * During journey to U.S. | | | | |
| * In U.S., not in ORR custody | | | | | | | * In ORR custody | | | | |
| **Sexual Activity History** | | | * Yes, specify below | | | * Denied, with no obvious signs/symptoms | | | | | | | * Denied, but obvious signs/symptoms present | | | | | * Unable to obtain/report response, specify reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **Sexual activity (Oral/Vaginal/Anal)** | | | | | | **Date of Last Encounter** | | | | | **Location** | | | | | | | | | | | | | | | | | | |
| **In home country** | | | | | **During journey to U.S.** | | | | **In U.S., not in ORR custody** | | | | | | | **In ORR custody** | | |
| * Consensual | | | | | | \_\_\_/\_\_\_/\_\_\_\_ | | | | |  | | | | |  | | | |  | | | | | | |  | | |
| Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Nonconsensual | | | | | | \_\_\_/\_\_\_/\_\_\_\_ | | | | |  | | | | |  | | | |  | | | | | | |  | | |
| Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Substance Use History** | | * Yes, specify below | | | | * Denied, with no obvious signs/symptoms | | | | | | | * Denied, but obvious signs/symptoms present | | | | | * Unable to obtain/report response, specify reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
|  | | | | **Alcohol** | | | | **Tobacco / Nicotine** | | | | | | **Marijuana** | | | | | **Injection drugs** | | | | | | | **Other substances** | | | |
| Specify substance(s) | | | |  | | | |  | | | | | | N/A | | | | |  | | | | | | |  | | | |
| Frequency of use | | | |  | | | |  | | | | | |  | | | | |  | | | | | | |  | | | |
| Date of last use | | | |  | | | |  | | | | | |  | | | | |  | | | | | | |  | | | |
| **Laboratory Testing** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Condition** | **Indicators** | | | | | | | | | **Test** | | | | | | | **Result** | | | | | | | | | | | | |
| Influenza | Fever + cough or sore throat | | | | | | | | | * Rapid flu | | | | | | | * Negative | * Positive, type: | | | | | * A | * B | | | | * A/B | * Unk |
| Strep throat | Sore throat + fever without cough | | | | | | | | | * Rapid strep | | | | | | | * Negative | * Positive | | | | | | | | | | | |
| Lead | 6 mos up to 6 yrs | | | | | | | | | * Capillary, Lead | | | | | | | * Ordered/Pending | | | | * Negative | | * Positive (>5 mcg/dl), level: \_\_\_ | | | | | | |
| * Blood/Serum, Lead | | | | | | | * Ordered/Pending | | | | | | | | | | | | |
| Pregnancy | ­>10 yrs or < 10 yrs who have reached menarche or sexual activity | | | | | | | | | * Urine pregnancy | | | | | | | * Negative | * Positive | | | | * Indeterminate | | | | | | | |
| * Blood/Serum hCG | | | | | | | * Ordered/Pending | | | | | | | | | | | | |
| HIV | >13 yrs or Sexual activity | | | | | | | | | * Rapid oral | | | | | | | * Negative | * Positive | | | | * Indeterminate | | | | | | | |
| * Blood/Serum, 4th Gen | | | | | | | * Ordered/Pending | | | | | | | | | | | | |
| Chlamydia | Sexual activity | | | | | | | | | * NAAT/PCR | | | | | | | * Ordered/Pending | | | | | | | | | | | | |
| Gonorrhea | Sexual activity | | | | | | | | | * NAAT/PCR | | | | | | | * Ordered/Pending | | | | | | | | | | | | |
| Syphilis | Sexual activity | | | | | | | | | * RPR/VRDL | | | | | | | * Ordered/Pending | | | | | | | | | | | | |
| Hepatitis B | Sexual activity or Injection drug use | | | | | | | | | * Surface antigen | | | | | | | * Ordered/Pending | | | | | | | | | | | | |
| Hepatitis C | Injection drug use | | | | | | | | | * Total antibody | | | | | | | * Ordered/Pending | | | | | | | | | | | | |
| Other Reportable Infectious Disease (Non-TB): | | | | | | | | | | Specify: | | | | | | | * Ordered/Pending | | | | | | | | | | | | |

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| **TB Lab Testing** (Use Supplemental TB Screening form for result documentation) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has minor ever been a close contact to a person with ***active*** TB disease? | | | | | | | | | | * No | | | * Yes, specify: | | | | | | | | | | | | | | | | | | |
| Has minor ever been treated for ***active*** TB disease? | | | | | | | | | | * No | | | * Yes, specify: | | | | | | | | | | | | | | | | | | |
| Has minor ever been treated for ***latent*** TB infection? | | | | | | | | | | * No | | | * Yes, specify: | | | | | | | | | | | | | | | | | | |
| **TB screening method ordered:** | | | | | | * TST (<2 yrs) | | | | | * IGRA (>2 yrs) | | | | | | * CXR (>15 yrs) | | | | | | | * Was or will be tested elsewhere | | | | | | | |
| **Diagnosis and Plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnosis:** | Minor with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | * No | * Yes |
| If **Yes**, check all diagnoses that apply. Specify in the space provided, where indicated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General/Constitutional** | | | | | | | | * Anemia | | | | | | | * Allergy (e.g., drug reaction, food allergy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| * Dehydration | | * Lead poisoning | | | | | | * Lymphadenopathy | | | | | | | * Malnourished | | | | | | | | | | * Pallor | | | | | | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HEENT** | | | | | | | | * Conjunctivitis | | | | | | | * Eyelid lesions | | | | | | | * Otitis media/externa | | | | | | | | * Rhinitis | |
| * Hearing issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | * Speech impediment | | | | | | | * Strep throat | | | | | | | | | | * Pharyngitis (Not strep throat) | | | | | | |
| * Vision issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| **Respiratory/Pulmonary** | | | | | | | | * Asthma | | | | | | * Chronic cough | | | | | | | | | * Abnormal CXR (Non-TB): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Lower respiratory illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | * Upper respiratory illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | * Influenza-like illness (ILI) | | | | | | |
| * Influenza, lab-confirmed | | | | | | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| **Cardiovascular** | | | | | | | | * Arrhythmia | | | | | | | * Elevated blood pressure | | | | | | | | | | * Chest pain | | | | | | |
| * Heart murmur | | * Syncope/fainting | | | | | | * Congenital heart disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| * Acquired heart disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| **Endocrine Disorder** | | | | | | | | * Diabetes, Type 1 and 2 | | | | | | | * Hyper/Hypothyroidism | | | | | | | | | | * Delayed/Precocious puberty | | | | | | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Gastrointestinal** | | | | | | | | * Abdominal pain | | | | | | | * Constipation | | | | | | * Celiac disease | | | | | | | * Diarrhea, Acute/Chronic | | | |
| * Failure to thrive | | * Gastritis/Peptic ulcer | | | | | | * Gastroenteritis | | | | | | | * GI bleeding | | | | | | * Heartburn/Reflux | | | | | | | * Jaundice | | | |
| * Liver disease | | * Weight loss | | | | | | * Inflammatory bowel disease | | | | | | | | | | | | * Intestinal parasites: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Genito-urinary/Reproductive** | | | | | | | | * Bed-wetting | | | | | | | * Hematuria | | | | | | | * Proteinuria | | | | | | | * Inguinal hernia | | |
| * Kidney stones | | * Urinary tract infection | | | | | | * Testicular torsion | | | | | | | * Hydrocele/Varicocele | | | | | | | | | | * Abnormal Vaginal Bleeding/Discharge | | | | | | |
| * Amenorrhea/Dysmenorrhea /Menorrhagia | | | | | | | | * Gynecomastia/Breast Mass (fibroadenomas, cysts) | | | | | | | | | | | | | | | | | * Consensual sexual activity | | | | | | |
| * Pelvic Inflammatory Disease | | | | | | | | * Genital warts | | | | | | | * Pregnant | | | | | | | | | | * Childbirth | | | | | | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Neurological** | | | | | | | | * Brain tumor | | | | | | | * Cerebral palsy | | | | | | | | | | * Cerebrovascular disease | | | | | | |
| * Cognitive disorder/IQ deficit | | | | | | | | * Developmental delay | | | | | | | * Headache/Migraine | | | | | | | | | | * Neurocysticercosis | | | | | | |
| * Traumatic brain injury / Concussion | | | | | | | | * Seizure/Epilepsy | | | | | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| **Musculoskeletal** | | | | | | | | * Back pain | | | | | | | * Extremity/Joint pain | | | | | | | | | | * Bone tumors (benign/malignant) | | | | | | |
| * Fracture | | | * Sprain/Strain | | | | | | * Scoliosis/Kyphosis | | | | | | | * Ligamentous/Tendon injury | | | | | | | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Skin, Hair, and Nails** | | | | | | | | * Acne | | | | | | | * Atopic dermatitis/Eczema | | | | | | | | | | * Allergic/Irritant Contact Dermatitis | | | | | | |
| * Lice | | | | * Scabies | | | | * Ingrown toenail | | | | | | | * Acanthosis Nigricans | | | | | | | | | | * Hair loss/Alopecia Areata | | | | | | |
| * Cellulitis | | | | * Ringworm | | | | * Tattoos | | | | | | | * Tinea pedis | | | | | | | | | | * Onychomycosis | | | | | | |
| * Scars | | | | * Warts | | | | * 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, active disease | | | | | | | | | | * TB, latent (LTBI) | | | | | | |
| * Typhoid fever | | | | * Varicella | | | | * Zika virus | | | | | | | * Viral hemorrhagic fever: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical, Other** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Behavioral and Mental Health Concerns** | | | | | | | | * Anxiety symptoms (e.g., panic attacks, excessive worry/fear) | | | | | | | | | | | | | | | | | | * Depressive symptoms | | | | | |
| * Manic symptoms (e.g., elated mood, pressured speech) | | | | | | | | | | | | * Trauma symptoms (e.g., nightmares, flashbacks) | | | | | | | | | | | | | | * Hallucinations | | | | | |
| * Delusions | | | | | * Behavioral concerns (e.g., aggression, trouble following rules) | | | | | | | | | | | | | | | | | | | | | * Social/Emotional delay | | | | | |
| * History of psychiatric diagnoses or treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | * Urge for/current self-harm | | | | | | | | * Urge for/current harm to others | | | | | |
| * Nonconsensual sexual activity | | | | | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
| **Dental** | | | | | | | | * Broken tooth or teeth | | | | | | | | | | | * Gingivitis/gum disease | | | | | | | | * Impacted tooth/teeth | | | | |
| * Infection/abscess | | | | * Tooth decay/caries | | | | * Tooth sensitivity | | | | | | | | | | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Plan:** Check all that apply and specify where indicated. Please provide copies of office notes, lab/imaging results, and immunization records to program staff. | | | | | | | | |
| Return to clinic:   * PRN/As needed | * Follow-up (specify diagnosis, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Minor fit to travel | * Yes | * No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Per program staff, discharge from ORR custody will be delayed: | | | | | * No | * Yes (specify diagnosis, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Minor has/may have an ADA disability: | | | * No | * Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| * Referred to specialist/counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Minor requires quarantine/isolation, specify diagnosis and timeframe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Medications (specify name, diagnosis treated, date started, dose, and directions and indicate if psychotropic): | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Immunizations given/validated from foreign record * List immunizations that were indicated, but not given and state why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Age-appropriate anticipatory guidance discussed and/or handout given | | | | | | | | |
| * Physical/dietary restrictions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Visiting nurse services required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Physical/Occupational/Speech therapy required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Durable medical equipment required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Per local/state reporting guidelines, Health Department was notified of suspect/confirmed diagnosis of a reportable infectious disease | | | | | | | | |
| Were other minors in ORR custody potentially exposed during infectious period? | | | | | | | * No | * Yes |
| Were grantee staff members potentially exposed at care provider program? | | | | | | | * No | * Yes |
| * Other: | | | | | | | | |
| **Recommendations from Healthcare Provider / Additional Information** | | | | | | | | |
|  | | | | | | | | |
| **Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_**  **Healthcare Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |

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