OMB Control No: 0970-0466
Expiration date: 12/31/2023

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

	Right Eye	Left Eye	Both eyes	Final
Corrected	20 /	20 /	20 /	• Pass • Fail
Uncorrected	20 /	20 /	20 /	• Pass • Fail

Hearing Screening: € No € Yes, specify below

OAE/ABR	• Pass	• Fail
Gross Hearing (< 4 Years)	• 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 C°) 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							

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
- € 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: _____

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: _____ € In home country € During journey to U.S.
_____ € In U.S., not in ORR custody € In ORR custody

• Part/All of abuse related to gang violence

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

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 to
- Infection/abscess
- Tooth decay/caries
- Tooth sensitivity
- Other: _____

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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