

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:		<input type="checkbox"/> 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):					Hearing Screening:				
	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 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							

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: _____				€ In home country € During journey to U.S. € In U.S., not in ORR € 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 • Blood/Serum, Lead	• Ordered/Pending • Negative • Positive (≥5 mcg/dl), level: ____
Pregnancy	≥10 yrs or < 10 yrs who have reached menarche or sexual activity	• Urine pregnancy • Blood/Serum hCG	• Negative • Positive • Indeterminate
HIV	≥13 yrs or Sexual activity	• Rapid oral • Blood/Serum, 4 th Gen	• Negative • Positive • Indeterminate
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

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
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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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