

## Health Assessment Form Unaccompanied Children's Program Office of Refugee Resettlement (ORR)

### General Information

<b>Minor</b>	Last name:		First name:		
	DOB:		A#:	Gender:	
<b>Healthcare Provider (HCP)</b>	Name: <span style="float: right;">MD / DO / PA / NP</span>		Clinic/Practice:		Specialty Type:
	Street address:		City or Town:	State:	Phone number:
	Location where child received care (e.g., Offsite clinic, ER):				Date evaluated:
<b>Program</b>	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		

<b>Allergies:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, specify below				
	<b>Food</b>	<b>Medication</b>	<b>Environmental</b>	<b>Other</b>
Allergen				
Reaction				

#### Medical History

**Concerns Expressed by Minor or Caregiver:**

#### Review of Systems (ROS) and Physical Exam

<b>Were any signs/symptoms reported by the minor or observed by program staff or HCP?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, check all applicable signs/symptoms and enter the onset date (mm/dd/yyyy):							
<b>Sign/Symptom</b>	• Pain, location: _____	• Fever (>37.8 C°) or chills	• Red Eyes	• Runny Nose	• Sore Throat	• Cough	• Difficulty breathing/ Shortness of Breath
<b>Onset Date</b>							
<b>Sign/Symptom</b>	• Nausea	• Vomiting	• Diarrhea	• Neck stiffness	• Headache	• Dizziness	• Confusion/Altered mental status
<b>Onset Date</b>							
<b>Sign/Symptom</b>	• Neurologic symptoms	• Skin lesions/Rash	• Yellow skin/eyes	• Swollen glands	• Unusual bleeding	• Other: _____	• Other: _____
<b>Onset Date</b>							

<b>Physical exam performed by HCP:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, enter the findings for each evaluated system		
System	Evaluated, Findings	Describe findings
General appearance	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
HEENT	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Neck	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Heart	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
GU/GYN	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Extremities	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Back/Spine	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Neurologic	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Skin (include tattoos)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Other _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

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	Previously elevated lead level	• Capillary, Lead	• Ordered/Pending • Negative • Positive (≥5 mcg/dl), level: ____
		• Blood/Serum, Lead	• Ordered/Pending
Pregnancy	Sexual activity	• Urine pregnancy	• Negative • Positive • Indeterminate
		• Blood/Serum hCG	• Ordered/Pending
HIV	Sexual activity	• Rapid oral	• Negative • Positive • Indeterminate
		• Blood/Serum, 4 <sup>th</sup> Gen	• Ordered/Pending
Chlamydia	Sexual activity	• NAAT/PCR	• Ordered/Pending
Gonorrhea	Sexual activity	• NAAT/PCR	• Ordered/Pending
Syphilis	Sexual activity	• RPR/VDRL	• Ordered/Pending
Hepatitis B	Sexual activity or Injection drug use	• Surface antigen	• Ordered/Pending
Hepatitis C	Injection drug use	• Antibody, Total	• Ordered/Pending
Active Tuberculosis	Active TB Work Up	€ AFB smear	• Ordered/Pending
		€ TB culture	• Ordered/Pending
		€ NAAT/PCR	• Ordered/Pending
		€ MDDR	• Ordered/Pending
		€ DST	• Ordered/Pending
Other Reportable Infectious Disease(s), specify:		Specify:	• Ordered/Pending

Diagnosis and Plan	
<b>Diagnosis:</b> Minor with new complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: € No, specify reason for exam (e.g., follow-up immunizations): _____ € Yes, check all diagnoses that apply below. Specify in the space provided, where indicated.	
<b>General/Constitutional</b> • Dehydration • Lead poisoning • Other: _____	• Anemia • Allergy (e.g., drug reaction, food allergy): _____ • Lymphadenopathy • Malnourished • Pallor
<b>HEENT</b> • Hearing issues: _____ • Vision issues: _____	• Conjunctivitis • Eyelid lesions • Otitis media/externa • Rhinitis • Speech impediment • Strep throat • Pharyngitis (Not strep throat)
<b>Respiratory/Pulmonary</b> • Lower respiratory illness: _____ • Influenza, lab-confirmed	• Asthma • Chronic cough • Abnormal CXR (Non-TB): _____ • Upper respiratory illness: _____ • Influenza-like illness (ILI) • Other: _____
<b>Cardiovascular</b> • Heart murmur • Syncope/fainting • Acquired heart disease: _____	• Arrhythmia • Elevated blood pressure • Chest pain • Congenital heart disease: _____ • Other: _____
<b>Endocrine Disorder</b> • Other: _____	• Diabetes, Type 1 and 2 • Hyper/Hypothyroidism • Delayed/Precocious puberty
<b>Gastrointestinal</b> • Failure to thrive • Gastritis/Peptic ulcer • Liver disease • Weight loss • Other: _____	• Abdominal pain • Constipation • Celiac disease • Diarrhea, Acute/Chronic • Gastroenteritis • GI bleeding • Heartburn/Reflux • Jaundice • Inflammatory bowel disease • Intestinal parasites: _____
<b>Genito-urinary/Reproductive</b> • Kidney stones • Urinary tract infection • Amenorrhea/Dysmenorrhea /Menorrhagia • Pelvic inflammatory disease • Pregnant: Current gestational age ____ wks, Est. due date __/__/____ • Spontaneous abortion • Elective abortion • Consensual sexual activity, who/when/where: _____ • Other: _____	• Bed-wetting • Hematuria • Proteinuria • Inguinal hernia • Testicular torsion • Hydrocele/Varicocele • Abnormal vaginal bleeding/Discharge • Gynecomastia/Breast Mass (fibroadenomas, cysts) • Genital warts • Childbirth
<b>Neurological</b> • Cognitive disorder/IQ deficit • Traumatic brain injury/Concussion	• Brain tumor • Cerebral palsy • Cerebrovascular disease • Developmental delay • Headache/Migraine • Neurocysticercosis • Seizure/Epilepsy • Other: _____
<b>Musculoskeletal</b> • Fracture • Sprain/Strain • Other: _____	• Back pain • Extremity/Joint pain • Bone tumors (benign/malignant) • Scoliosis/Kyphosis • Ligamentous/Tendon injury
<b>Skin, Hair, and Nails</b> • Lice • Scabies • Cellulitis • Ringworm • Scars • Warts • Other: _____	• Acne • Atopic dermatitis/Eczema • Allergic/Irritant contact dermatitis • Ingrown toenail • Acanthosis nigricans • Hair loss/Alopecia areata • Tattoos • Tinea pedis • Onychomycosis • Other: _____
<b>Potentially Reportable Infectious Disease</b>	• Acute hepatitis A • Acute/chronic hepatitis B • Acute/chronic hepatitis C

- Chikungunya
- HIV
- Rubella
- Typhoid fever
- Other: \_\_\_\_\_
- Chlamydia
- Malaria
- Sepsis/Meningitis
- Varicella
- COVID-19
- Measles
- Syphilis
- Zika virus
- Dengue
- Mumps
- TB, active disease
- Viral hemorrhagic fever: \_\_\_\_\_
- Gonorrhea
- Pertussis
- TB, latent (LTBI)

**Medical, Other**

- Behavioral and Mental Health Concerns**
- Manic symptoms (e.g., elated mood, pressured speech)
  - Delusions
  - History of psychiatric diagnoses/treatment: \_\_\_\_\_
  - Nonconsensual sexual activity, who/when/where: \_\_\_\_\_
  - Anxiety symptoms (e.g., panic attacks, excessive worry/fear)
  - Trauma symptoms (e.g., nightmares, flashbacks)
  - Behavioral concerns (e.g., aggression, trouble following rules)
  - Urge for/current self-harm
  - Other: \_\_\_\_\_
  - Depressive symptoms
  - Hallucinations
  - Social/Emotional delay
  - Urge for/current harm to others

- DSM diagnosis if criterion met (select from following options):**
- Bipolar disorder
  - Oppositional defiant disorder
  - Conduct disorder
  - Panic disorder
  - Major depressive disorder
  - Acute stress disorder/PTSD
  - ADHD
  - Adjustment disorder
  - Eating disorder
  - Primary psychotic disorder
  - Autism
  - Generalized anxiety disorder
  - Other: \_\_\_\_\_

- Dental**
- Infection/abscess
  - Broken tooth or teeth
  - Gingivitis/gum disease
  - Other: \_\_\_\_\_
  - Tooth decay/caries
  - Tooth sensitivity
  - Impacted tooth/teeth

**Plan:** Check all that apply and specify where indicated. Please provide copies of office notes, lab/imaging results, and immunization records. 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: \_\_\_\_\_
- € Minor requires quarantine/isolation, specify diagnosis and timeframe: \_\_\_\_\_
- € Medications (specify name, reason, date started, dose, and directions and indicate if psychotropic): \_\_\_\_\_
- € Immunizations given
- € List immunizations that were indicated, but not given and state why: \_\_\_\_\_
- € Age-appropriate anticipatory guidance discussed and/or handout given
- € Surgery/procedure needed/performed: \_\_\_\_\_
- € 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 shelter? • No • Yes
- € Other: \_\_\_\_\_

**Recommendations from Healthcare Provider / Additional Information**

**Healthcare Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Healthcare Provider Printed Name:** \_\_\_\_\_

The purpose of this information collection is to provide ORR with critical health information for unaccompanied children in the care of ORR. Public reporting burden for this collection of information is estimated to average 9 minutes per healthcare provider, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (6 U.S.C. §279: Exhibit 1, part A.2 of the Flores Settlement Agreement (Jenny Lisette Flores, et al., v. Janet Reno, Attorney General of the United States, et al., Case No. CV 85-4544-RJK [C.D. Cal. 1996])). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0509 and the expiration date is 12/31/2023. If you have any comments on this collection of information, please contact [UACPolicy@acf.hhs.gov](mailto:UACPolicy@acf.hhs.gov).

