

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

### General Information

<b>Child</b>	Last name:		First name:				
	DOB:	A#:	Gender:	Date evaluated:	Time evaluated:		
	Primary language:		Who provided appropriate language services for child during evaluation?		• HCP fluent in child's primary language	• Trained interpreter	• Not provided
<b>Evaluating Healthcare Provider (HCP)</b>	Name:		MD / DO / PA / NP		Phone number:		Clinic or Practice:
	Street address:			City/Town:		State:	
	Location where child received care (e.g., Primary health care provider/Pediatrician, medical specialist):						
<b>Program</b>	Program name:				• Program Staff Member Present During Exam with HCP		
<b>Reason for visit:</b>	• Initial medical exam (IME)* • Specialist visit, type: _____		• New complaint/concern • Routine well-child check/Establish care		• Follow-up visit with PCP for previous complaint/concern		

### History and Assessment\*

#### Vital Signs

Temperature (T)	Heart Rate (HR)	BP (≥ 3 yrs)	Resp Rate (RR)	Height (HT)	Weight (WT)	BMI (≥2 yrs)	BMI %ile
°C				cm	kg		

**Allergies:**  No  Yes, specify below:

	Food	Medication	Environmental
Allergen			
Reaction			

<b>Vision Screening (≥ 3 years):</b> <input type="checkbox"/> Yes, specify below <input type="checkbox"/> Not performed				<b>Hearing Screening:</b> <input type="checkbox"/> Yes, specify below <input type="checkbox"/> Not performed			
	Right Eye	Left Eye	Both eyes	Final	OAE/ABR (Preferred for < 4 years)		• Pass • Fail
Corrected	20 /	20 /	20 /	• Pass • Fail	Pure Tone Audiometry (Preferred for ≥ 4 years)		• Pass • Fail
Uncorrected	20 /	20 /	20 /	• Pass • Fail	Gross Hearing (Acceptable for all ages)		• Pass • Fail

**Medical & Mental Health History (including dates & locations of care)**

Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Chronic/Underlying conditions: \_\_\_\_\_

Family: \_\_\_\_\_

Healthcare received in DHS custody/during journey: \_\_\_\_\_

**Medications (dosage frequency & dates):**  Past: \_\_\_\_\_  Current: \_\_\_\_\_

**Reproductive History (complete for anatomically female UC who have started menarche):**

Date of LMP: \_\_\_ / \_\_\_ / \_\_\_, if unknown, months since LMP: \_\_\_\_\_ • Current contraceptive use

Pregnancy: Gravida \_\_\_\_\_ Parity \_\_\_\_\_; location & age of child(ren): \_\_\_\_\_ • Currently breastfeeding

**History of abuse:**  Yes, specify  Denied, with no obvious signs  Denied, but obvious signs present  Unknown

Type(s):  Verbal  Emotional  Physical, specify: \_\_\_\_\_

• Sexual (with or without penetration), estimated date of last encounter: \_\_\_ / \_\_\_ / \_\_\_\_\_

• Other victimization (e.g., gang, bullying, crime): \_\_\_\_\_

**Consensual sexual activity (with penetration):**  No  Yes, estimated date of last encounter: \_\_\_ / \_\_\_ / \_\_\_ • Unknown

**Substance use:**  Yes, specify  Denied, with no obvious signs/symptoms  Denied, but obvious signs/symptoms present  Unknown

	Alcohol	Tobacco/Nicotine	Marijuana	Injection drugs (IDU)	Other substances
Specify substance(s)			N/A		
Frequency/Quantity					
Date of last use					

**Travel history:** \_\_\_\_\_

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

**Concerns expressed by child/caregiver:** No  Yes, specify: \_\_\_\_\_

or observed by program staff or HCP?							
<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>							

**Physical Examination\***

Systems	Normal findings	Abnormal findings, specify or if not evaluated, give reason:
General	• Well-appearing/nourished; no distress; developmentally appropriate	•
Head/Neck	• Normocephalic, neck supple; no adenopathy or masses	•
Eyes	• PERRL, EOMI; no redness/discharge	•
ENT/Dental	• TMs WNL; no rhinorrhea; o/p w/o erythema, lesions, caries, abscess	•
Cardiovascular	• Regular rate & rhythm; no murmurs; normal pulses; cap refill < 3 sec	•
Lungs	• Clear to auscultation, no wheezes, crackles, rhonchi, no accessory muscle use	•
Abdomen	• Non-distended; soft and non-tender; no masses or organomegaly	•
Genitourinary	• External GU normal; Tanner ____: no lesions, discharge, hernia	•
Musculoskeletal/ Back/Extremities	• Full range of motion of all extremities; no joint swelling, erythema; no scoliosis	•
Neurologic	• Typical gait, strength, tone, sensation, speech & behavior for age	•
Skin	• No rashes, lesions, jaundice, pallor, scars, birthmarks, or tattoos	•
Other:		

**Were any mental health signs/symptoms reported by the child or observed by program staff or HCP?** • No • Yes, specify below:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Feels empty, hopeless, sad, numb more often than not</li> <li>• Feels constantly worried, anxious, nervous more often than not</li> <li>• Experiences mood swings, from very high to very low</li> <li>• Relives traumatic events from the past</li> <li>• Feels easily annoyed or irritated</li> <li>• Feels afraid, easily startled, jumpy</li> <li>• Has trouble concentrating, restless, too many thoughts</li> </ul> | <ul style="list-style-type: none"> <li>• Has trouble eating, sleeping</li> <li>• Has nightmares</li> <li>• Engages in self-harm</li> <li>• Hears voices or sees things others do not see (hallucinations)</li> <li>• Thoughts of hurting others</li> <li>• Thoughts of hurting self, would be better dead</li> <li>• Other concerns: _____</li> </ul> |
|--|---|

Is child able to attribute these feelings to a specific reason(s)? • No • Yes, specify: \_\_\_\_\_

**Laboratory Testing\***

Condition	Indicators	Test	Result
CBC w/ diff	<6 yrs <u>at IME</u>	• Blood/Serum	• Ordered • Pending; collected: ___/___/___
Lead	<6 yrs, lactating or pregnancy <u>at IME</u>	• Capillary, Lead • Blood/Serum, Lead	• Negative • Positive (≥3.5 µg/dL), level: ___ • Ordered • Pending; collected: ___/___/___
Pregnancy	≥10 yrs or <10 yrs who have reached menarche <u>at IME</u> , sexual activity/abuse/assault	• Urine pregnancy	• Negative • Positive • Indeterminate
HIV	All children <u>at IME</u>	• Rapid, fingerstick/oral • Blood/Serum, 4 <sup>th</sup> Gen	• Negative • Positive • Indeterminate • Ordered • Pending; collected: ___/___/___
Syphilis	<2 yrs & not with biological mother <u>at IME</u> , sexual activity/abuse/assault	• RPR/VDRL	• Ordered • Pending; collected: ___/___/___
Chlamydia	Sexual activity/abuse/assault	• NAAT/PCR	• Ordered • Pending; collected: ___/___/___
Gonorrhea	Sexual activity/abuse/assault	• NAAT/PCR	• Ordered • Pending; collected: ___/___/___
Hepatitis B	Pregnancy, sexual abuse/assault, IDU, country-based	• Surface antigen	• Ordered • Pending; collected: ___/___/___
Hepatitis C	Pregnancy, IDU	• Total antibody	• Ordered • Pending; collected: ___/___/___
COVID-19	<u>Any</u> COVID-19 symptom, incl. but not ltd. to runny nose, sore throat, cough, headache, diarrhea	Rapid: • Ag • PCR • NAAT/PCR	• Negative • Positive • Indeterminate • Ordered • Pending; collected: ___/___/___
Influenza	Fever + cough or sore throat	• Rapid flu	• Negative • Positive, type(s): • A • B • Unk
Strep throat	Sore throat + fever without cough, HCP discretion	• Rapid strep	• Negative, • culture ordered • Positive
Other Reportable Infectious Disease (Non-TB):	Specify: _____		• Ordered • Pending; collected: ___/___/___
	Specify: _____		• Ordered • Pending; collected: ___/___/___

**TB Screening\***

Has child ever been exposed to a person with **active** TB disease? € No € Yes, specify: \_\_\_\_\_

Has child ever been treated for TB? • No • Yes, specify type & details: • Active TB disease • Latent TB infection (LTBI)

TB screening indicator	Test	Result
<2 yrs of age at IME	• PPD/Tuberculin skin test (TST)	€ Ordered    € Pending; date performed: ___/___/___, date read: ___/___/___; Result (mm): ___
≥2 yrs of age at IME	TB blood test (IGRA): • QuantiFERON® -TB Gold In-Tube test (QFT-GIT) € T-SPOT® .TB test (T-Spot)	€ Ordered    € Pending; collected: ___/___/___
≥15 yrs of age at IME	€ Single view (PA) CXR	€ Ordered    € Pending; performed: ___/___/___
<15 yrs and + TST/IGRA or exposure/treatment history	€ 2-view (PA and lateral) CXR	€ Ordered    € Pending; performed: ___/___/___

**TB Screening Outcome:** € Pending    € Negative for TB condition; No further follow up needed    € TB, Latent (LTBI)    € Referred to Health Department/ specialist for active TB evaluation    € Not performed: \_\_\_\_\_

**If referred to HD/specialist, was an active TB work-up initiated?**  
 • No, specify reason: \_\_\_\_\_  
 • Yes, specify reason: • Signs/Symptoms    • Abnormal imaging    • Exposure history    • Initiation of LTBI treatment    • Other: \_\_\_\_\_  
 • Specimen collected by HD/specialist:    Specimen type: \_\_\_\_\_    Tests ordered: \_\_\_\_\_

**Diagnosis and Plan\***

**Diagnosis:** Child 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	HEENT	Respiratory/Pulmonary	Cardiovascular	Gastrointestinal
<ul style="list-style-type: none"> <li>Allergic reaction</li> <li>Allergy: _____</li> <li>Anemia</li> <li>Dehydration</li> <li>Developmental delay</li> <li>Lead in blood</li> <li>Fatigue</li> <li>Lymphadenopathy</li> <li>Obesity</li> <li>Sickle cell disease</li> <li>Underweight/Weight loss</li> <li>Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Allergic rhinitis</li> <li>Cerumen impaction</li> <li>Conjunctivitis</li> <li>Hearing issues: _____</li> <li>Otitis externa</li> <li>Otitis media</li> <li>Pharyngitis, strep</li> <li>Pharyngitis, other</li> <li>Vision issues: _____</li> <li>Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Abnormal CXR (Non-TB): _____</li> <li>Asthma, severity: _____</li> <li>Bronchiolitis</li> <li>Chronic cough</li> <li>Croup</li> <li>Influenza, lab-confirmed</li> <li>Influenza-like illness (ILI)</li> <li>Pneumonia</li> <li>Shortness of breath/wheezing</li> <li>Upper respiratory illness</li> <li>Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Arrhythmia</li> <li>Chest pain</li> <li>Congenital heart disease: _____</li> <li>High blood pressure</li> <li>Heart murmur</li> <li>Myocarditis/Pericarditis/Endocarditis</li> <li>Syncope/Fainting</li> <li>Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Abdominal pain</li> <li>Appendicitis</li> <li>Constipation</li> <li>Diarrhea, acute/chronic</li> <li>Failure to thrive</li> <li>Gastritis/Peptic ulcer</li> <li>Gastroenteritis</li> <li>GI bleeding</li> <li>Heartburn/Reflux</li> <li>Inflammatory bowel disease</li> <li>Intestinal parasites: _____</li> <li>Jaundice</li> <li>Liver disease</li> <li>Nausea/Vomiting</li> <li>Other: _____</li> </ul>
Dental		Endocrine Disorder		
<ul style="list-style-type: none"> <li>Broken tooth/teeth</li> <li>Gingivitis/Gum disease</li> <li>Impacted tooth/teeth</li> <li>Infection/abscess</li> </ul>	<ul style="list-style-type: none"> <li>Missing tooth/teeth</li> <li>Tooth decay/caries</li> <li>Tooth sensitivity</li> <li>Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Acanthosis nigricans</li> <li>Delayed/Precocious puberty</li> <li>Diabetes, Type 1 and 2</li> </ul>	<ul style="list-style-type: none"> <li>Hyper/Hypothyroidism</li> <li>Short stature</li> <li>Other: _____</li> </ul>	
Genito-urinary/Reproductive		Musculoskeletal	Potentially Reportable Infectious Disease	
<ul style="list-style-type: none"> <li>Abnormal vaginal bleeding/Discharge</li> <li>Amenorrhea/Menorrhagia/Dysmenorrhea</li> <li>Bed-wetting</li> <li>Childbirth</li> <li>Consensual sexual activity</li> <li>Elective abortion</li> <li>Genital lesions</li> <li>Gynecomastia/Benign breast mass</li> <li>Herpes simplex virus</li> <li>Inguinal hernia</li> </ul>	<ul style="list-style-type: none"> <li>Kidney disease/stones</li> <li>Menstrual cramping/pain</li> <li>Pelvic inflammatory disease</li> <li>Pregnant, gestational age: _____ wks; est. due date: ___/___/___</li> <li>Proteinuria/Hematuria</li> <li>Sexual abuse/assault</li> <li>Spontaneous abortion</li> <li>Testicular pain/Torsion</li> <li>Urinary tract infection</li> <li>Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Back pain</li> <li>Bone tumors (benign/malignant)</li> <li>Extremity/Joint pain</li> <li>Fracture</li> <li>Hematoma/Bruise</li> <li>Ligamentous/Tendon injury</li> <li>Myalgia</li> <li>Scoliosis/Kyphosis</li> <li>Sprain/Strain</li> <li>Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Acute hepatitis A</li> <li>Acute/chronic hepatitis B</li> <li>Acute/chronic hepatitis C</li> <li>Chikungunya</li> <li>Chlamydia</li> <li>COVID-19</li> <li>Dengue</li> <li>Gonorrhea</li> <li>HIV</li> <li>Malaria</li> <li>Measles</li> <li>Mumps</li> </ul>	<ul style="list-style-type: none"> <li>Pertussis</li> <li>Rubella</li> <li>Sepsis/Meningitis</li> <li>Syphilis</li> <li>TB, active disease</li> <li>TB, latent (LTBI)</li> <li>Typhoid fever</li> <li>Varicella</li> <li>Zika virus</li> <li>Viral hemorrhagic fever: _____</li> <li>Other: _____</li> </ul>
Neurological		Skin, Hair, and Nails		
<ul style="list-style-type: none"> <li>Brain tumor</li> <li>Cerebral palsy</li> <li>Cerebrovascular disease</li> <li>Headache/Migraine</li> <li>Seizure/Epilepsy</li> </ul>	<ul style="list-style-type: none"> <li>Traumatic brain injury/Concussion</li> <li>Vertigo/Dizziness</li> <li>Weakness</li> <li>Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Acne</li> <li>Atopic dermatitis/Eczema</li> <li>Cellulitis/Abscess</li> <li>Contact dermatitis</li> <li>Diaper rash</li> <li>Hair loss/Alopecia areata</li> </ul>	<ul style="list-style-type: none"> <li>Impetigo</li> <li>Ingrown toenail</li> <li>Lice</li> <li>Onychomycosis</li> <li>Scabies</li> <li>Scars</li> </ul>	<ul style="list-style-type: none"> <li>Tattoos</li> <li>Tinea pedis/corporis/cruris/capitis</li> <li>Urticaria</li> <li>Warts</li> <li>Other: _____</li> </ul>

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
- Urge for/current harm to others
- History of psychiatric diagnoses or treatment: \_\_\_\_\_
- Urge for/current self-harm
- 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*

- € Immunizations administered during visit
- € Immunizations documented on foreign record reviewed and validated
- € Immunizations indicated but not given; specify: \_\_\_\_\_
- € Age-appropriate anticipatory guidance discussed and/or handout given
- € Child educated on healthcare services received and treatment recommendations
- € Medications administered/prescribed:

Medication Name	Reason	Date Started	Expected end date	Dose	Directions	Psychotropic?

- € Child requires isolation for a communicable disease; specify diagnosis, start/end dates: \_\_\_\_\_
- Child has special healthcare needs that require accommodation while admitted in ORR care; specify condition/reason, time frame and frequency:
  - € Onsite care provider clinician evaluation: \_\_\_\_\_
  - € Increased level of supervision for mental health concern: \_\_\_\_\_
  - € Assistance with daily living activities: \_\_\_\_\_
  - € Durable medical equipment: \_\_\_\_\_
  - € Physical activity restrictions: \_\_\_\_\_
  - € Dietary restrictions: \_\_\_\_\_
  - € Other: \_\_\_\_\_
- € Child has/may have an ADA disability: \_\_\_\_\_
- Child has health concerns that require follow-up services; specify needs and time frame by when services should occur:
  - Return to clinic: \_\_\_\_\_
  - Mental health specialist evaluation: \_\_\_\_\_
  - Medical specialist evaluation: \_\_\_\_\_
  - Physical/Occupational/Speech therapy: \_\_\_\_\_
  - Surgery/Procedure needed/performed: \_\_\_\_\_
  - Other, specify: \_\_\_\_\_

**Child cleared to travel:**

- Yes, with no restrictions
- Yes, with restrictions (e.g., ground travel, travel safety plan, travel length): \_\_\_\_\_
- No, reason: \_\_\_\_\_

**Recommendations from Healthcare Provider / Additional Information**

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

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

