|  |
| --- |
| **Medical Assessment Form** **Unaccompanied Children’s Program****Office of Refugee Resettlement (ORR)** |
| **General Information** |
| **Child** | 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
 |
| **Evaluating Healthcare Provider (HCP)** | 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): |
| **Program**  | Program name: | * Program Staff Member Present During Exam with HCP
 |
| **Reason for visit:** | * Initial medical exam (IME)\*
 | * New complaint/concern
 | * Follow-up visit with PCP for previous complaint/concern
 |
| * Specialist visit, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Routine well-child check/Establish care
 |
| **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** |
|  0C |  |  |  |  cm  |  kg  |  |  |
| **Allergies:**  | * No
 | * Yes, specify below:
 |
|  | **Food** | **Medication** | **Environmental** |
| Allergen |  |  |  |
| Reaction |  |  |  |
| **Vision Screening** (> 3 years): | * Yes, specify below
 | * Not performed
 | **Hearing Screening:** | * Yes, specify below
 | * 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:

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|  |  |  |
| --- | --- | --- |
| **Were any physical signs/symptoms reported by the child 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** |  |  |  |  |  |  |  |
| **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:
 |
| * Feels empty, hopeless, sad, numb more often than not
 | * Has trouble eating, sleeping
 |
| * Feels constantly worried, anxious, nervous more often than not
 | * Has nightmares
 |
| * Experiences mood swings, from very high to very low
 | * Engages in self-harm
 |
| * Relives traumatic events from the past
 | * Hears voices or sees things others do not see (hallucinations)
 |
| * Feels easily annoyed or irritated
 | * Thoughts of hurting others
 |
| * Feels afraid, easily startled, jumpy
 | * Thoughts of hurting self, would be better dead
 |
| * Has trouble concentrating, restless, too many thoughts
 | * Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| 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 at IME | * Blood/Serum
 | * Ordered
 | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_
 |
| Lead | <6 yrs, lactating or pregnancy at IME | * Capillary, Lead
 | * Negative
 | * Positive (>3.5 μg/dL), level: \_\_\_\_\_
 |
| * Blood/Serum, Lead
 | * Ordered
 | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_
 |
| Pregnancy | ­>10 yrs or <10 yrs who have reached menarche at IME, sexual activity/abuse/assault | * Urine pregnancy
 | * Negative
 | * Positive
 | * Indeterminate
 |
| HIV | All children at IME | * Rapid, fingerstick/oral
 | * Negative
 | * Positive
 | * Indeterminate
 |
| * Blood/Serum, 4th Gen
 | * Ordered
 | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_
 |
| Syphilis  | <2 yrs & not with biological mother at IME, 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 | Any COVID-19 symptom, incl. but not ltd. to runny nose, sore throat, cough, headache, diarrhea | Rapid: | * Ag
 | * PCR
 | * Negative
 | * Positive
 | * Indeterminate
 |
| * NAAT/PCR
 | * 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: \_\_\_\_/\_\_\_\_/\_\_\_\_\_
 |

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| --- |
| **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)
 | * Ordered
 | * Pending; collected: \_\_\_\_/\_\_\_\_/\_\_\_\_\_
 |
| * T-SPOT®.TB test (T-Spot)
 |
| >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** |
| * Allergic reaction
* Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Anemia
* Dehydration
* Developmental delay
* Lead in blood
* Fatigue
* Lymphadenopathy
* Obesity
* Sickle cell disease
* Underweight/Weight loss
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Allergic rhinitis
* Cerumen impaction
* Conjunctivitis
* Hearing issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Otitis externa
* Otitis media
* Pharyngitis, strep
* Pharyngitis, other
* Vision issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Abnormal CXR (Non-TB): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Asthma, severity: \_\_\_\_\_\_\_\_\_
* Bronchiolitis
* Chronic cough
* Croup
* Influenza, lab-confirmed
* Influenza-like illness (ILI)
* Pneumonia
* Shortness of breath/wheezing
* Upper respiratory illness
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Arrhythmia
* Chest pain
* Congenital heart disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* High blood pressure
* Heart murmur
* Myocarditis/Pericarditis/ Endocarditis
* Syncope/Fainting
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Abdominal pain
* Appendicitis
* Constipation
* Diarrhea, acute/chronic
* Failure to thrive
* Gastritis/Peptic ulcer
* Gastroenteritis
* GI bleeding
* Heartburn/Reflux
* Inflammatory bowel disease
* Intestinal parasites: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Jaundice
* Liver disease
* Nausea/Vomiting
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Dental** | **Endocrine Disorder** |
| * Broken tooth/teeth
* Gingivitis/Gum disease
* Impacted tooth/teeth
* Infection/abscess
 | * Missing tooth/teeth
* Tooth decay/caries
* Tooth sensitivity
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Acanthosis nigricans
* Delayed/Precocious puberty
* Diabetes, Type 1 and 2
 | * Hyper/Hypothyroidism
* Short stature
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Genito-urinary/Reproductive** | **Musculoskeletal** | **Potentially Reportable Infectious Disease** |
| * Abnormal vaginal bleeding/Discharge
* Amenorrhea/Menorrhagia /Dysmenorrhea
* Bed-wetting
* Childbirth
* Consensual sexual activity
* Elective abortion
* Genital lesions
* Gynecomastia/Benign breast mass
* Herpes simplex virus
* Inguinal hernia
 | * Kidney disease/stones
* Menstrual cramping/pain
* Pelvic inflammatory disease
* Pregnant, gestational age: \_\_\_\_\_ wks; est. due date: \_\_\_/\_\_\_\_/\_\_\_\_\_\_
* Proteinuria/Hematuria
* Sexual abuse/assault
* Spontaneous abortion
* Testicular pain/Torsion
* Urinary tract infection
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Back pain
* Bone tumors (benign/malignant)
* Extremity/Joint pain
* Fracture
* Hematoma/Bruise
* Ligamentous/Tendon injury
* Myalgia
* Scoliosis/Kyphosis
* Sprain/Strain
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Neurological** | **Skin, Hair, and Nails** |
| * Brain tumor
* Cerebral palsy
* Cerebrovascular disease
* Headache/Migraine
* Seizure/Epilepsy
 | * Traumatic brain injury/ Concussion
* Vertigo/Dizziness
* Weakness
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Acne
* Atopic dermatitis/Eczema
* Cellulitis/Abscess
* Contact dermatitis
* Diaper rash
* Hair loss/Alopecia areata
 | * Impetigo
* Ingrown toenail
* Lice
* Onychomycosis
* Scabies
* Scars
 | * Tattoos
* Tinea pedis/corporis/ cruris/capitis
* Urticaria
* Warts
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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