

## 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:		Phone number:		Clinic or Practice:		
	<b>MD / DO / PA / NP</b>			City/Town:		State:	
	Street address:						
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)*		• 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
°C				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	Uncorrected	Corrected	Uncorrected	Corrected	Uncorrected	• Pass	• Fail	Pure Tone Audiometry (Preferred for ≥ 4 years)	Gross Hearing (Acceptable for all ages)	• Pass	• Fail
	20 /	20 /	20 /	20 /	20 /	20 /	• Pass	• Fail			• Pass	• Fail
	20 /	20 /	20 /	20 /	20 /	20 /	• Pass	• Fail			• 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: \_\_\_ / \_\_\_ / \_\_\_, • Approximate • Exact • Contraceptive use, specify (e.g., IUD, pills): \_\_\_\_\_  
 Pregnancy history: • No • Yes, # of: vaginal deliveries \_\_\_\_, C-sections \_\_\_\_, miscarriages/abortions \_\_\_\_, ectopics \_\_\_\_, living children \_\_\_\_  
 Pregnancy/Postpartum complications: \_\_\_\_\_ • 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:

<b>Were any physical signs/symptoms reported by the child 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: _____	<input type="checkbox"/> Fever (>37.8 C°) or chills	<input type="checkbox"/> Red Eyes	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Cough	<input type="checkbox"/> Difficulty breathing/ Shortness of Breath
<b>Onset Date</b>							
<b>Sign/Symptom</b>	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck stiffness	• Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Confusion/Altered mental status
<b>Onset Date</b>							
<b>Sign/Symptom</b>	<input type="checkbox"/> Neurologic symptoms	<input type="checkbox"/> Skin lesions/Rash	<input type="checkbox"/> Yellow skin/eyes	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Unusual bleeding	<input type="checkbox"/> Other:	<input type="checkbox"/> 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:

<b>Were any mental health signs/symptoms reported by the child or observed by program staff or HCP?</b> <input type="checkbox"/> No <input type="checkbox"/> 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)?	<input type="checkbox"/> No <input type="checkbox"/> 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	• Negative • Positive (≥3.5 µg/dL), level: _____
Pregnancy	≥10 yrs or <10 yrs who have reached menarche <u>at IME</u> , sexual activity/abuse/assault	• Blood/Serum, Lead	• Ordered • Pending; collected: ___/___/___
HIV	All children <u>at IME</u>	• Urine pregnancy	• Negative • Positive • Indeterminate
		• Rapid, fingerstick/oral	• Negative • Positive • Indeterminate
Syphilis	<2 yrs & not with biological mother <u>at IME</u> , sexual activity/abuse/assault	• Blood/Serum, 4 <sup>th</sup> Gen	• Ordered • Pending; collected: ___/___/___
		• 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	• 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	Specify:	• Ordered	• Pending; collected: ___/___/___

Disease (Non-TB):	Specify:	<input type="checkbox"/> Ordered <input type="checkbox"/> 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)	<input type="checkbox"/> Ordered	<input type="checkbox"/> 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) <input type="checkbox"/> T-SPOT® .TB test (T-Spot)	<input type="checkbox"/> Ordered	<input type="checkbox"/> Pending; collected: ___/___/___
≥15 yrs of age at IME	<input type="checkbox"/> Single view (PA) CXR	<input type="checkbox"/> Ordered	<input type="checkbox"/> Pending; performed: ___/___/___
<15 yrs and + TST/IGRA or exposure/treatment history	<input type="checkbox"/> 2-view (PA and lateral) CXR	<input type="checkbox"/> Ordered	<input type="checkbox"/> 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 discharge</li> <li>• Abortion</li> <li>• Amenorrhea/Abnormal uterine bleeding</li> <li>• Bed-wetting</li> <li>• Childbirth</li> <li>• Consensual sexual activity</li> <li>• Genital lesions</li> <li>• Gynecomastia/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>• Miscarriage</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>• 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** Page 3 of 4

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

**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**

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

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

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: 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 13 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 0970-0466 and the expiration date is 10/31/2026. If you have any comments on this collection of information, please contact [UACPolicy@acf.hhs.gov](mailto:UACPolicy@acf.hhs.gov).