

Medical Assessment Form Unaccompanied Alien Children Bureau Office of Refugee Resettlement (ORR)

General Information

Child	Last name:		First name:				
	DOB:	A#:	Sex:	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:		Phone number:		Clinic or Practice:		
	MD / DO / PA / NP			City/Town:		State:	
	Street address:						
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
°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:

Were any physical signs/symptoms reported by the child or observed by program staff or HCP? <input type="checkbox"/> No <input type="checkbox"/> Yes, check all applicable signs/symptoms and enter the onset date (mm/dd/yyyy)							
Sign/Symptom	• 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
Onset Date							
Sign/Symptom	<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
Onset Date							
Sign/Symptom	<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:
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? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify below:	
<ul style="list-style-type: none"> • Feels empty, hopeless, sad, numb more often than not • Feels constantly worried, anxious, nervous more often than not • Experiences mood swings, from very high to very low • Relives traumatic events from the past • Feels easily annoyed or irritated • Feels afraid, easily startled, jumpy • Has trouble concentrating, restless, too many thoughts 	<ul style="list-style-type: none"> • Has trouble eating, sleeping • Has nightmares • Engages in self-harm • Hears voices or sees things others do not see (hallucinations) • Thoughts of hurting others • Thoughts of hurting self, would be better dead • Other concerns: _____
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 th 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: _____ • 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"> Allergic reaction Allergy: _____ Anemia Dehydration Developmental delay Lead in blood Fatigue Lymphadenopathy Obesity Sickle cell disease Underweight/Weight loss Other: _____ 	<ul style="list-style-type: none"> Allergic rhinitis Cerumen impaction Conjunctivitis Hearing issues: _____ Otitis externa Otitis media Pharyngitis, strep Pharyngitis, other Vision issues: _____ Other: _____ 	<ul style="list-style-type: none"> 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: _____ 	<ul style="list-style-type: none"> Arrhythmia Chest pain Congenital heart disease: _____ High blood pressure Heart murmur Myocarditis/Pericarditis/Endocarditis Syncope/Fainting Other: _____ 	<ul style="list-style-type: none"> 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		
<ul style="list-style-type: none"> Broken tooth/teeth Gingivitis/Gum disease Impacted tooth/teeth Infection/abscess 	<ul style="list-style-type: none"> Missing tooth/teeth Tooth decay/caries Tooth sensitivity Other: _____ 	<ul style="list-style-type: none"> Acanthosis nigricans Delayed/Precocious puberty Diabetes, Type 1 and 2 	<ul style="list-style-type: none"> Hyper/Hypothyroidism Short stature Other: _____ 	
Genito-urinary/Reproductive		Musculoskeletal	Potentially Reportable Infectious Disease	
<ul style="list-style-type: none"> Abnormal vaginal discharge Abortion Amenorrhea/Abnormal uterine bleeding Bed-wetting Childbirth Consensual sexual activity Genital lesions Gynecomastia/Breast mass Herpes simplex virus Inguinal hernia 	<ul style="list-style-type: none"> Kidney disease/stones Menstrual cramping/pain Miscarriage Pelvic inflammatory disease Pregnant, gestational age: _____ wks; est. due date: ___/___/___ Proteinuria/Hematuria Sexual abuse/assault Testicular pain/Torsion Urinary tract infection Other: _____ 	<ul style="list-style-type: none"> Back pain Bone tumors (benign/malignant) Extremity/Joint pain Fracture Hematoma/Bruise Ligamentous/Tendon injury Myalgia Scoliosis/Kyphosis Sprain/Strain Other: _____ 	<ul style="list-style-type: none"> Acute hepatitis A Acute/chronic hepatitis B Acute/chronic hepatitis C Chikungunya Chlamydia COVID-19 Dengue Gonorrhea HIV Malaria Measles Mumps 	<ul style="list-style-type: none"> 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		

- | | | | | |
|---|--|--|--|--|
| <ul style="list-style-type: none"> Brain tumor Cerebral palsy Cerebrovascular disease Headache/Migraine Seizure/Epilepsy | <ul style="list-style-type: none"> Traumatic brain injury/Concussion Vertigo/Dizziness Weakness Other: _____ | <ul style="list-style-type: none"> Acne Atopic dermatitis/Eczema Cellulitis/Abscess Contact dermatitis Diaper rash Hair loss/Alopecia areata | <ul style="list-style-type: none"> Impetigo Ingrown toenail Lice Onychomycosis Scabies Scars | <ul style="list-style-type: none"> Tattoos Tinea pedis/corporis/cruris/capitis Urticaria Warts Other: _____ |
|---|--|--|--|--|

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- 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

Healthcare Provider Signature: _____ **Date:** ____/____/____

Healthcare Provider Printed Name: _____

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